STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #96364, #96405, and #96331.	F 000		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 60 residents with a sample of 4 residents. Based on observation, record review, and interview the facility failed to update the resident's care plans for 4 of 4 sampled residents. Resident #1 after admission/readmission, Resident #4 for falls and change in status, and Resident #2, and #3 for	F 280		3/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/25/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 1	F 280		

falls.

Findings included:

- Resident #1's physician order sheet, dated 1/6/16, included diagnoses of constipation (difficulty passing stools), gastro-esophageal reflux (back flow of stomach contents to the esophagus), flatulence (excess stomach or intestinal gas), ulcerative colitis (inflammation and ulcers in the stomach and bowels), and diarrhea (stool discharged from the bowel in liquid form).

The quarterly (MDS) Minimum Data Set assessment, dated 11/18/15, identified the resident had intact cognition, was independent with his/her (ADLs) Activities of Daily Living, and received a diuretic (a medication that increases the volume of urine excreted) 7 days a week. A diuretic draws fluid from the body, which dries stool and leads to constipation. The MDS indicated the resident was continent of urine and bowel, and not on a toileting program.

The 11/30/15 care plan directed staff to monitor for the side effects of Synthroid (a replacement for a thyroid hormone), which include diarrhea, stomach cramping, and irritability, Lasix (a diuretic), and ferrous sulfate (contributes to slowing the normal bowel movement). The care plan revealed the resident independent with toileting and personal hygiene. The 1/22/16 update directed the staff to assess the resident's abdomen and bowel sounds with each complaint of abdominal pain, bloating, or feeling constipated. The 2/5/16 update directed the staff to provide 1 staff assistance with the colostomy (an opening from the wall of the intestine through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 2	F 280		

the abdominal wall, permitting passage of stool through the opening), which includes emptying and rinsing out the bag. (11 days after readmission to the facility with a colostomy)

Review of the progress notes between 1/1/16 and 1/6/16 revealed the resident complained of nausea and vomiting with an upset stomach 11 times, with 3 documented episodes the resident had vomited. The clinical record lacked evidence the staff assessed the resident or listened to his/her bowel sounds at the time the resident stated he/she had symptoms.

The 1/6/16 at 8:10 AM, progress note stated the nurse talked with the resident in his/her room as he/she sat on the bedside, and threw up into a garbage can. The resident stated to the nurse, he/she had bowel problems and no one would listen to him/her. The resident reported he/she had diarrhea on January 1st, was bloated and sick since Sunday. The resident reported he/she manually removed stool from his/her rectum on Monday (1/4/16). The staff member administered MOM, and listened to the resident's bowel sounds. The resident had faint bowel sounds in all 4 quadrants. The nurse scheduled an appointment for the resident to see the physician.

On 1/6/16 at 12:33 PM, the physician dictated a history and physical revealing the resident's abdomen was firm and distended, tender in the right upper quadrant, and had hypoactive bowel sounds. The resident reported to the physician, he/she had pain in his/her abdomen, nausea, and could not have a bowel movement. The physician documented the resident had a small bowel movement 4 days ago, the nausea and vomiting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 3	F 280		

increased, and the resident had poor intake of food or fluids. The physician admitted the resident to the hospital for abdominal pain and planned to evaluate the white blood cell count, obtain an X-ray for large loops of air and bowel, bowel rest, and further evaluation. The physician admitted the resident to the hospital for a large bowel obstruction and leukocytosis.

On 1/15/16 at 8:26 AM, the physician's hospital (H&P) history and physical following the resident's acute care stay revealed diagnoses of large Bowel Obstruction, (a partial or complete blockage of the large intestine) Colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body), and weakness. The H&P stated the physician performed a bowel resection with a loop colostomy (a procedure used in emergencies, where a loop of the large bowel is pulled out to the abdomen surface and an opening is created called a stoma for stool and mucous).

On 1/25/16, the physician gave orders to readmit the resident to the facility and provided medication and treatment orders for the resident's care.

On 2/8/16 at 3:10 PM, observation revealed the resident sat in a recliner, in an upright position, with a slight bulge under the resident's shirt, where the ostomy (opening in the body for discharge of body wastes) bag attached to his/her abdomen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 4	F 280		

On 2/8/16 at 3:10 PM, the resident indicated he/she had vomited on 1/1/16 and asked staff for a dose of MOM. The nurse informed the resident a physician's order would be needed. The resident stated he/she requested MOM, not Mylanta, and clarified he/she needed a laxative. The resident stated the next day (1/2/16), he/she vomited, while 2 nurses stood in the room doorway and informed him/her MOM was not appropriate, since he/she had diarrhea, and the medication might make it worse. The resident stated on 1/6/16, a nurse assessed his/her bowel sounds and noticed his/her stomach had gotten bigger. The resident stated he/she asked the nurse for MOM every day from the first day (1/1/16) to the day he/she went to the hospital 1/6/16 (5 days later).

On 2/9/16 at 3:40 PM, Administrative Nurse A verified the care plan did not reflect the health concerns the resident has, including constipation, diarrhea, and stated after his/her readmission the care plan should address the colostomy care.

The facility failed to ensure staff updated Resident #1's care plan following readmission from the hospital, where Resident #1 was treated for nausea and vomiting, diarrhea, upset stomach, had a bowel obstruction, and required a colostomy.

- Resident #4's admission physician orders, dated 12/29/15, included Resident #4's diagnoses of multiple sacral (large triangular bone between the two hip bones) fractures, dementia (progressive mental disorder characterized by failing memory, confusion) with atypical psychosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 5	F 280		

(any major mental disorder characterized by a gross impairment in reality testing), and generalized weakness. The admission orders described the resident as incapable of making decisions, required total care, walked with assistance, full weight bearing, and experienced weakness. The physician ordered (PT) Physical therapy and (OT) Occupational therapy to evaluate and treat the resident as indicated for generalized weakness.

The quarterly (MDS) Minimum Data Set assessment, dated 10/18/15, stated the resident had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 8, with verbal behaviors toward others, and required limited assistance of 1 staff for bed mobility, dressing, and hygiene. The MDS stated the resident required supervision of transfers by 1 staff and was independent with walking in his/her room, the hallways, and with toileting. The assessment stated the resident's balance was unsteady with transfers, standing, walking, and toileting. The assessment further stated the resident could regain his/her balance without assistance. The resident used a wheeled walker, and had 1 fall since the last assessment.

The readmission MDS, dated 1/5/16, revealed the facility readmitted the resident from an acute care hospital, and he/she had moderately impaired cognition with a (BIMS) Brief Interview of Mental Status score of 9, verbal behaviors, required extensive assistance of 2 persons for (ADLs) Activities of Daily Living, his/her balance was unsteady and he/she required physical assistance from staff to rebalance. The MDS indicated the resident had a urinary catheter and an ostomy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 6	F 280		

(surgical creation of an artificial opening on the stomach wall to excrete feces from the body) bag, received antidepressant and antibiotic medications, had 1 fall with injury after readmission, 12 falls with injury in the month prior to readmission, and worked with PT and OT.

The cognitive loss (CAA) Care Area Assessment, dated 1/11/16, stated the resident had dementia, confused at times, and needed reoriented by staff.

The fall CAA, dated 1/11/16, indicated PT and OT worked with the resident to gain strength and the resident participated in the walk to dine program, walking short distances with a gait belt, and required assistance of 1-2 staff.

The Morse Fall scale, dated 12/29/15, indicated the resident a high risk for falls with a score of 90. (A score greater than 45 degrees is considered high risk).

The 10/24/15 care plan, directed staff to provide a feather lite walker and assistance of 1 staff, with a gait belt for ambulation in his/her room and the hallways. The care plan further directed staff to ensure shoes were comfortable and not slippery, or gripper socks were on his/her feet when walking. The care plan directed staff to consult PT and/or OT to evaluate and provide treatment as needed.

Review of the care plan revealed no revision after the readmission on 12/29/15 from hospitalization for multiple sacral fractures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 7	F 280		

The 1/18/16 care plan update, 21 days after readmission from acute hospitalization for a pelvic fracture, instructed staff to provide assistance of 1-2 staff for ambulation, with a gait belt. The 1/20/16 care plan update directed staff to complete hourly safety checks, and to apply a bed alarm.

The 1/25/16 care plan (4 days after readmission), directed staff to provide a wheelchair for activities outside of his/her room, and the resident required assistance from 1 staff to propel the wheelchair.

The 12/29/15 resident's transfer record, dated 12/29/15, stated the resident could not make decisions and directed staff to transfer and walk the resident with assistance of 1 staff.

The 1/11/16 at 2:58 PM, progress notes revealed the physician directed to discontinue the resident's indwelling urinary catheter.

The 1/17/16 at 12:01 AM, progress notes indicated staff entered the resident's room and found him/her sitting on the floor in the bathroom, with his/her back and head in the corner, and the call light not on. The note further indicated the resident stated he/she attempted to go to the bathroom without staff assistance. Staff last checked on the resident at 11:05 PM, and found the resident resting quietly in bed. The note indicated the resident complained of pain to his/her head, left hand, hip, and upon standing the resident's left leg turned outward. The note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 8	F 280		

further indicated staff received a physician's order to transfer the resident to the emergency room for evaluation and treatment.

Review of the incident revealed the resident's admission order directed staff to provide assistance of 1 for ambulation, as the resident could not make safe decisions as outlined in the physician's 12/29/15 transfer sheet.

The 1/17/16, X-ray evaluation revealed the resident had a radial fracture (broken arm bone) to his/her left arm/wrist.

The 1/18/16 (untimed), progress note revealed the nurse indicated the root cause analysis revealed the fall was due to the resident's impaired cognitive function, the resident did not recognize his/her limitations, and was not oriented to reality. The note further indicated the resident required physical assistance with transfers and ambulation, did not use his/her call light for assistance, and did not wait until staff could help him/her. The note indicated staff reviewed the care plan.

On 2/9/16 at 9:31 AM, observation revealed Nurse Aide F and Nurse Aide G assisted the resident to transfer from a lying to a sitting position. Further observation revealed staff applied a gait belt, and with one staff on each side of the resident, cued him/her to stand, placed the wheeled walker in front of the resident, without locking the brakes. Continued observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 9	F 280		

revealed staff lifted a large portion of the resident's weight, using the gait belt, and provided stability for the resident to stand. The resident's legs appeared slightly forward, with his/her upper body bent minimally at the waistline. The pressure from the resident's body weight caused his/her walker to move slightly, and the resident stated his/her feet were slipping. Further observation revealed the resident's feet did not slip with the gripper socks on, he/she walked forward, requiring staff to maintain balance for the resident as he/she walked to the toilet in the bathroom. Observation revealed the resident turned too early to sit down on the toilet seat, and voiced being tired. Staff continued with the transfer, but did not stop or offer the resident a wheelchair. Nurse Aide G quickly cued the resident to move to the left, but the resident did not follow instructions, sat on the toilet riser arm rest, and Nurse Aide G moved the resident's hips to the commode seat.

On 2/8/16 at 10:49 PM, Nurse D stated the resident transferred and walked independently in his/her room with a wheeled walker following admission from his/her prior hospital stay (11/19/15 to 12/29/15), and verified the resident's mobility status did not change. Nurse D further verified at times the resident did use the call light to request assistance, and staff assisted him/her with personal cares.

On 2/8/16 at 11:38 PM, Nurse Aide J verified on 1/17/16, staff found the resident on the bathroom floor, with his/her feet up, no gait belt around the resident's waist, and the call light not on. Nurse Aide J verified the staff should accompany the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 10	F 280		

resident into the bathroom, with his/her wheeled walker. Nurse Aide J verified the resident had increased confusion at night, and occasionally used the call light system to request staff assistance.

On 2/9/16 at 3:20 PM, Administrative Nurse A verified the facility did not use the 3 day bladder assessment, and verified staff are expected to update the resident's care plan after a fall, on admission/readmission, and with any change in health status. Administrative Nurse A further verified the resident's need to use the bathroom could have contributed to his/her falls, and had not been assessed by the facility.

The facility's 1/4/2013 Fall Documentation policy instructed staff to document all falls for the purpose to identify root causes of the falls, to determine effectiveness of interventions, and track trends and injuries from the falls to safely maintain and/or to improve the resident's mobility and to minimize injury. The policy further directed staff the charge nurse is to update the care plan with interventions that are appropriate to prevent further falls.

The facility failed to provide Resident #4 with adequate supervision to prevent falls, when staff failed to thoroughly assess for causative factors for falls or/and implement appropriate interventions to prevent additional falls, and the resident fell during the night, attempting to toilet, and sustained a wrist fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 11	F 280		

- Resident #2's annual (MDS) Minimum Data Set assessment, dated 1/17/16, indicated the resident had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 10, required limited assistance from staff for dressing and bathing, and was independent with his/her other (ADLs) Activities of Daily Living. The MDS further indicated the resident's balance was unsteady, although he/she could rebalance his/herself, had occasional incontinence of urine and bowel, no trial toileting program, and shortness of breath with exertion. The MDS revealed the resident participated 6 days on a restorative program for range of motion and communication, and had 2 non-injury falls since the prior assessment.

The Falls (CAA) Care Area Assessment, dated 1/15/15, indicated the resident had a history of falling when he/she went to the bathroom. The CAA further verified the resident fell to seek attention, and knew if he/she fell a nurse would come down to see him/her. The CAA indicated the resident used a walker, had a bed alarm for nighttime use, and staff cued the resident to focus on walking when he/she was up, to limit the risk for falling.

The 1/29/15 care plan instructed staff to remind the cognitively impaired resident to use his/her call light for staff assistance, and to remind the resident to be alert and careful when he/she walked through a congested area. The care plan further directed staff to encourage the resident to keep his/her bedside table at the foot of the bed, while in recliner, and educated the resident to maintain a clutter free environment. The care plan directed staff to review safety hazards around the resident's room, floor, and furniture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 12	F 280		

The care plan informed staff when the resident is upset he/she does not pay attention to safety hazards or surroundings. The care plan instructed staff to educate the resident on the importance of making slow position changes, and to remind the resident to wear gripper socks or shoes over plain socks.

The 2/3/16 care plan stated the resident walked independently with a wheeled walker, received restorative therapy for range of motion, and directed staff to monitor for side effects of medications related to dizziness. The care plan further directed staff to cue the resident to use the bathroom prior to meals, and may use a wheelchair in place of walking due to the resident's right arm in a sling.

The Morse Fall Scale, dated 1/7/15, indicated the resident at high risk for falling.

Review of the medical record revealed no 3 day bladder assessment to determine the resident's voiding patterns.

Review of the medical record revealed the resident had falls related to bathroom use.

The 6/24/15 fall investigation report stated staff found the resident seated on the floor in his/her room. The resident had sneakers on, pants pulled around his/her waist, his/her walker outside the bathroom door, the alarm not turned on, and did not sound. The root cause analysis stated the resident lost his/her balance when he/she tried to pull his/her pants up. The staff failed to turn on the alarm notifying staff the resident was up. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 13	F 280		

reviewed the care plan, and lacked completion of a 3 day bladder diary to develop the care plan, to ensure the resident receives assistance. Staff discontinued the alarm, with the date not documented.

The 10/24/15 fall investigation report stated staff found the resident lying on the floor between the bathroom door and the recliner. The light was off, with the walker across the room, and regular socks on. The resident reported he/she slipped and fell on the way back from the bathroom. Staff assessed the resident for injury, none found, and reviewed the pajama pants, but not the use of regular socks. The nurse did not complete a 3 day bladder diary to develop the care plan, to ensure the resident receives assistance with toileting.

The 1/21/16 at 2:30 PM, progress notes revealed the physician evaluated the resident for right shoulder pain, and the X-ray report indicated the resident had a mild irregularity of the non-displaced clavicle (shoulder), suggestive of a fracture. The note further indicated the physician ordered staff to place a sling on the resident's right arm.

The 2/8/16 fall investigation report stated staff found the resident seated on the floor, walker in front of him/her, and the call light was pushed after the resident slid to the floor. The resident stated he/she stood to use the bathroom, his/her knee gave out and he/she slid down the side of the bed. Staff completed a physical assessment, and raised the resident off the floor with assistance of 2 staff with a gait belt and walker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 14	F 280		

The nurse failed to utilize a 3 day bladder diary to develop the care plan, to ensure the resident receives assistance.

The 2/19/16 X-ray report revealed no fracture, dislocation or abnormality of the resident's unilateral clavicle.

On 2/9/16 at 1:06 PM, observation revealed Nurse Aide K assisted the resident to transfer from the wheelchair to the recliner. Continued observation revealed staff did not apply a gait belt, and provided stand by assistance. Further observation revealed as the resident seated him/herself, his/her body twisted in the chair seat and Nurse Aide K cued the resident to pivot his/her body in the chair for proper positioning.

On 2/8/16 at 3:28 PM, the resident stated he/she had fallen in the bathroom, and stood back up on his/her own. The resident further verified the walker slid to the side and he/she lost his/her balance. The resident indicated staff assisted him/her to the bathroom currently, when he/she uses the call light.

On 2/9/16 at 3:23 PM, Nurse Aide K verified the resident walked independently, prior to the fall when he/she injured his/her shoulder. Nurse Aide K further verified the resident used a wheelchair, after the resident unsuccessfully tried to grasp the walker with his/her injured shoulder and arm, and walk. Nurse Aide K stated the resident experienced pain and had difficulty hanging onto the walker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 15	F 280		

On 2/9/16 at 3:20 PM, Nurse I verified the facility did not complete 3 day bladder assessment as a part of the MDS assessment process, or as required by the facility's policy. Nurse I stated another nurse completed interviews with the staff about the time frames the resident toileted and a toileting care plan was developed based on the staff response to the questions. Nurse I further verified a 3 day bladder assessment provided a better picture of the resident's toileting, mobility, and safety needs, and would assist staff to prevent falls.

On 2/9/16 at 3:20 PM, Administrative Nurse A verified the staff are expected to update the resident's care plan after a fall, on admission/readmission, and with any change in health status. Administrative Nurse A further verified the staff had not assessed the resident's voiding pattern with a 3 day bladder assessment and the resident's need to use the bathroom could have contributed to his/her falls.

The facility's 11/1/2011 Bowel and Bladder Management policy instructed staff a scheduled toileting plan must be included in each resident's care plan and directed staff to follow a scheduled toileting plan, document the care plan intervention provided, scheduled times each day, where staff is to toilet the resident, give the resident a urinal or bed pan, or remind the resident to go to the toilet. The policy directed staff to do an assessment upon admission, with a change in bowel or urinary habits, staff initiate a bowel monitoring record, which is documented for 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 16	F 280		

days, and assisted to establish a resident's individual bowel and urinary pattern.

The facility's 1/4/2013 Fall Documentation policy instructed staff to document all falls for the purpose to identify root causes of the falls, to determine effectiveness of interventions, and track trends and injuries from the falls to safely maintain and/or to improve the resident's mobility and to minimize injury. The policy further directed staff the charge nurse is to update the care plan with interventions that are appropriate to prevent further falls.

The facility failed to provide adequate supervision to prevent falls, and utilize the root cause analysis, including a 3 day bladder assessment after Resident #2 had falls attempting to independently toilet, resulting in a fall injuring his/her right shoulder.

- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 5/28/15, revealed the resident had severely impaired cognition with a (BIMS) Brief Interview of Mental Status score of 5, required extensive assistance from 1-2 staff for (ADLs) Activities of Daily Living, not on a bladder or bowel toileting program, and was frequently incontinent of bowel and bladder. The MDS further indicated the resident had 1 non-injury fall since the last assessment.

The ADL (CAA) Care Area Assessment, dated 12/1/15, stated the resident required assistance of 2 staff, and a gait belt, for toileting. The CAA further indicated staff would provide short commands, for the resident to understand, and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 17	F 280		

provide assistance with cares.

The 12/11/15 care plan directed staff to walk the resident with 1 staff assistance, use a gait belt, a walker, provide a wheelchair for long distances, provide extensive assistance to turn and reposition in bed, transfers, and toilet. The care plan directed staff to accompany the resident in the bathroom at 7:30 AM, 11:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, 9:00 PM, and 2:00 AM/5:30 AM (if awake). The care plan further directed staff to ensure shoes are comfortable and not slippery, and to seat the resident in his/her recliner between meals.

The Morse Fall Scale, dated 5/23/15, indicated the resident at a high risk for falls, with a score of 75. The Morse Fall Scale instructions stated any score greater than 45 should be considered a high risk for falls. The medical record revealed staff assessed the resident a high fall risk on 6/9/15, 8/10/15, 8/20/15, 8/25/15, 11/28/15, 11/29/15, 12/17/15, 12/30/15, 1/28/15, and 2/8/16.

Review of the medical record revealed a 3 day bladder assessment had not been completed as a part of the MDS assessments.

The medical record revealed the resident had several falls related to bathroom use and/or incontinence and falls in his/her room. The medical record further revealed the nurse notified the physician and responsible party about the incidents, but did not make a long term care plan intervention after each fall to help prevent future falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 18	F 280		

The 8/10/15 fall investigation report revealed staff found the resident seated on the floor with his/her legs bent, feces on the floor behind him/her, and the resident stated he/she slipped trying to go to the bathroom. The nurse identified the resident's incontinence of stool as the root cause. Staff reviewed the care plan and initiated an intervention to toilet the resident between 4:00 and 5:00 PM, due to urgency with bowel and bladder.

The 8/20/15 fall investigation report revealed staff found the resident on the floor, seated upright, incontinent of stool, and the alarms had not sounded. The resident stated he/she attempted to go to the bathroom. The root cause stated the resident did not remember he/she could not get up to the bathroom unassisted. Staff reviewed the care plan and initiated an intervention to toilet the resident, after meals, to prevent incontinence.

The 11/29/15 fall investigation report revealed staff found the resident lying face down in his/her room, incontinent of stool, and had a 3 (cm) centimeter x 2 cm hematoma (solid swelling of clotted blood within the tissues) to his/her left forehead. The root cause revealed the resident becomes anxious to go to the bathroom when he/she has diarrhea, required more supervision at that time, and needed to be in the wheelchair to allow the resident to be assisted to the bathroom faster.

The 12/17/15 fall investigation report revealed the staff found the resident in his/her room on the floor, with urine noted on the floor. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 19	F 280		

reported he/she rolled out of bed. Staff reviewed the care plan, and were directed to toilet the resident before 4:00 PM and to place a mat on the floor beside the bed.

The 12/30/15 fall investigation report revealed staff found the resident lying on his/her left side in the bathroom, with his/her pants and attends pads wrapped around his/her knees, and gripper socks on. The resident stated he/she hit his/her head and had a small bump to the left back side of the head. The resident stated he/she fell off the toilet. The root cause revealed the CNA had left the resident alone on the toilet, when the CNA should not have left the resident's side, since the resident could not use the call light for assistance. Staff reviewed the care plan and initiated an intervention for staff to not leave the resident alone on the toilet in his/her room, due to the high fall risk.

The 1/28/16 fall investigation report revealed staff found the resident seated on the floor in front of the television in the east lounge area. The nurse assessed the resident and found no injury. Staff transferred the resident to a wheelchair and assisted him/her to the snack bar area. Review of the video camera revealed the resident became restless and scooted to the edge of the chair and lowered him/herself to the floor. Staff reviewed the care plan and added an intervention to toilet the resident when he/she was restless in the recliner and then place in the wheelchair and take to the east television room for closer monitoring.

On 2/8/16, the physician order sheet, directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 20	F 280		

staff to perform hourly visual checks to ensure the resident's safety.

On 2/9/16 at 3:20 PM, Nurse I verified the facility did not complete a 3 day bladder assessment as a part of the MDS assessment process, or as required by the facility's policy. Nurse I stated another nurse completed interviews with the staff about the time frames the resident toileted and a toileting care plan was developed based on the staff response to the questions. Nurse I further verified a 3 day bladder assessment provided a better picture of the resident's toileting, mobility, and safety needs, and would assist staff to prevent falls.

On 2/9/16 at 3:20 PM, Administrative Nurse A verified the facility did not use the 3 day bladder assessment, and verified staff are expected to update the resident's care plan after a fall, on admission/readmission, and with any change in health status. Administrative Nurse A further verified the resident's need to use the bathroom could have contributed to his/her falls, and had not been assessed by the facility.

The 11/1/2011 Bowel and Bladder Management policy instructed staff a scheduled toileting plan must be included in each resident's care plan and directed staff to follow a scheduled toileting plan, document the care plan intervention provided, scheduled times each day, where staff is to toilet the resident, give the resident a urinal or bed pan, or remind the resident to go to the toilet. The policy directed staff to do an assessment upon admission, with a change in bowel or urinary habits, staff initiate a bowel monitoring record,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 280	Continued From page 21 which is documented for 3 days, and assisted to establish a resident's individual bowel and urinary pattern. The facility's 1/4/2013 Fall Documentation policy instructed staff to document all falls for the purpose to identify root causes of the falls, to determine effectiveness of interventions, and track trends and injuries from the falls to safely maintain and/or to improve the resident's mobility and to minimize injury. The policy further directed staff the charge nurse is to update the care plan with interventions that are appropriate to prevent further falls. The facility failed to ensure staff completed a thorough assessment, including the 3 day voiding diary, and utilize the root cause analysis to develop care plan interventions for Resident #3, who had falls related to the need to toilet.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 60 residents. The sample included 4 residents. Based on	F 309		3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 22	F 309		

observation, interview and record review the facility failed to ensure proper monitoring, treatment and services, including a thorough assessment for bowel sounds, and seek physician involvement for 1 of 3 residents sampled for bowel continence, who developed a bowel obstruction, required hospitalization, and resulted in a colostomy (an artificial opening from the colon through the abdominal wall, bypassing a damaged part of the colon, allowing feces to be excreted). (#1)

Findings included:

- Resident #1's physician order sheet, dated 1/6/16, included diagnoses of constipation (difficulty passing stools), gastro-esophageal reflux (back flow of stomach contents to the esophagus), flatulence (excess stomach or intestinal gas), ulcerative colitis (inflammation and ulcers in the stomach and bowels), and diarrhea (stool discharged from the bowel in liquid form).

The quarterly (MDS) Minimum Data Set assessment, dated 11/18/15, identified the resident had intact cognition, was independent with his/her (ADLs) Activities of Daily Living, and received a diuretic (a medication that increases the volume of urine excreted) 7 days a week. A diuretic draws fluid from the body, which dries stool and leads to constipation. The MDS indicated the resident was continent of urine and bowel, and not on a toileting program.

The 11/30/15 care plan directed staff to monitor for the side effects of Synthroid (a replacement for a thyroid hormone), which include diarrhea, stomach cramping, and irritability, Lasix (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 23	F 309		

diuretic), and ferrous sulfate (contributes to slowing the normal bowel movement). The care plan revealed the resident independent with toileting and personal hygiene. The 1/22/16 update directed the staff to assess the resident's abdomen and bowel sounds with each complaint of abdominal pain, bloating, or feeling constipated. The 2/5/16 update directed the staff to provide 1 staff assistance with the colostomy - emptying and rinsing out the bag.

On 1/1/16 at 6:36 PM, nurse's notes stated the resident complained of (N/V) nausea and vomiting and epigastric distress (discomfort to the upper region of the abdomen), and requested some Mylanta (medication used to treat heartburn and an upset stomach, which contains aluminum hydroxide). The nurse's note further stated the resident later reported relief from the symptoms. The clinical record lacked evidence the staff assessed the resident or listened to his/her bowel sounds. The Federal Drug Administration website revealed Mylanta contained aluminum hydroxide (a potential side effect of nausea and vomiting, stomach upset, constipation, or diarrhea.

Review of the progress notes between 1/1/16 and 1/6/16 revealed the resident complained of nausea and vomiting with an upset stomach 11 times, with 3 documented episodes the resident had vomited. The clinical record lacked evidence the staff assessed the resident or listened to his/her bowel sounds at the time the resident stated he/she had symptoms.

Review of the January 16, 2016 (MAR) medication administration record and progress notes revealed staff administered Mylanta double

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 24	F 309		

strength suspension, 30 (ml) milliliters for complaints of heartburn (burning sensation in the chest) and indigestion (stomach upset) on the following dates:

1/1/16 at 10:25 PM - Medication Effective
1/2/16 at 00:45 AM - Medication Effective
1/2/16 at 2:13 AM - Medication Effective
1/2/16 at 5:17 AM - Medication Effective
1/5/16 at 1:15 PM - Medication Effective
1/5/16 at 2:30 PM - Medication Effective
1/5/16 at 8:23 PM - Medication Effective
1/5/16 at 9:07 PM - Medication Effective

Staff administered (MOM) Milk of Magnesia (laxative), 30 ml for constipation on 1/6/2016 at 08:34 AM.

The Bowel Movement Record revealed the resident had the following bowel elimination:

1/1/16 at 1:57 PM, a large formed stool.

1/1/16 at 9:59 PM, a large loose diarrhea stool.

(1/2/16 at 5:17 AM, progress note revealed the resident reported he/she had an upset stomach and diarrhea, with no strong odor, on the evening shift.

1/2/16 at 5:50 AM the BM Record stated the resident had a medium loose stool.

1/2/16 at 1:57 PM, a large formed stool.

(1/2/16 at 4:15 PM, progress note stated staff administered Tylenol (non-narcotic pain medication), 2 - 325 (mg) milligrams, by mouth,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 25	F 309		

for stomach upset).

1/3/16 at 1:59 PM, a medium formed stool.

1/4/16 at 1:59 PM, a large formed stool.

1/4/16 at 3:26 PM, a medium loose/diarrhea stool.

1/5/16 at 1:59 PM a medium formed stool.

The 1/6/16 at 8:10 AM, progress note stated the nurse spoke to the resident in his/her room as he/she sat on the bedside, and threw up into a garbage can. The resident stated to the nurse, he/she had bowel problems and no one would listen to him/her. The resident reported he/she had diarrhea on January 1st, was bloated and sick since Sunday. The resident reported he/she manually removed stool from his/her rectum on Monday (1/4/16). The staff member administered MOM, and listened to the resident's bowel sounds. The resident had faint bowel sounds in all 4 quadrants. The nurse scheduled an appointment for the resident to see the physician. On 2/18/16, Nurse L described the resident's emesis on 1/6/16 at 8:10 AM as clear, with mucous.

On 1/6/16 at 12:33 PM, the physician dictated a history and physical revealing the resident's abdomen was firm and distended, tender in the right upper quadrant, and had hypoactive bowel sounds. The resident reported to the physician, he/she had pain in his/her abdomen, nausea, and could not have a bowel movement. The physician documented the resident had a small bowel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 26	F 309		

movement 4 days ago, the nausea and vomiting increased, and the resident had poor intake of food or fluids. The physician admitted the resident to the hospital for abdominal pain and planned to evaluate the white blood cell count, obtain an X-ray for large loops of air and bowel, bowel rest, and further evaluation. The physician admitted the resident to the hospital for a large bowel obstruction and leukocytosis.

On 1/15/16 at 8:26 AM, the physician's hospital (H&P) history and physical following the resident's acute care stay revealed diagnoses of large Bowel Obstruction, (a partial or complete blockage of the large intestine) Colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body), and weakness. The H&P stated the physician performed a bowel resection with a loop colostomy (a procedure used in emergencies, where a loop of the large bowel is pulled out to the abdomen surface and an opening is created called a stoma for stool and mucous).

On 1/25/16, the physician gave orders to readmit the resident to the facility and provided medication and treatment orders for the resident's care.

On 2/8/16 at 3:10 PM, observation revealed the resident sat in a recliner, in an upright position, with a slight bulge under the resident's shirt, where the ostomy (opening in the body for discharge of body wastes) bag attached to his/her abdomen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 27 On 2/8/16 at 3:10 PM, the resident indicated he/she had vomited on 1/1/16 and asked staff for a dose of MOM. The nurse informed the resident a physician's order would be needed. The resident stated he/she requested MOM, not Mylanta, and clarified he/she needed a laxative. The resident stated the next day (1/2/16), he/she vomited, while 2 nurses stood in the room doorway and informed him/her MOM was not appropriate, since he/she had diarrhea, and the medication might make it worse. The resident stated on 1/6/16, a nurse assessed his/her bowel sounds and noticed his/her stomach had gotten bigger. The resident stated he/she asked the nurse for MOM every day from the first day (1/1/16) to the day he/she went to the hospital 1/6/16 (5 days later). On 2/8/16 at 11:35 PM, Nurse Aide C stated the resident did ask for MOM for stomach upset and the nurse explained to the resident, he/she had loose/diarrhea stool, and the medication could make that worse. On 2/8/16 at 10:49 AM, Nurse D verified he/she did not do a physical assessment of the resident's abdomen when the resident voiced complaints of constipation and flatulence between 1/1/16 and 1/6/16. Nurse D documented on 2 different dates the resident complaints of upset stomach with nausea and administered Mylanta 2 times on 1/5/16. Nurse D verified he/she did not complete a physical assessment for bowel sounds and abdominal distention at the time the resident made the complaints, but verified the assessment should have been done.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 28	F 309		

On 2/9/16 at 2:08 PM, Nurse E verified he/she did not do a physical assessment of the resident's abdomen, or administer Mylanta, when the resident voiced complaints of constipation and flatulence between 1/1/16 and 1/6/16, which he/she worked 3 days of the time frame. Nurse E stated, he/she and Nurse D explained to the resident, taking MOM would make the diarrhea worse, and suggested Mylanta in place of the MOM. Nurse E stated the resident removed BM from his/her rectum, and a thorough assessment including bowel sounds, would have been appropriate.

On 2/9/16 at 3:40 PM, Administrative Nurse A verified the staff should have done a physical assessment of the resident's abdomen and listened for bowel sounds. Nurse A verified the care plan did not reflect the health concerns the residents has, constipation, diarrhea, and stated after his/her readmission the care plan should address the colostomy care.

The facility's (undated) Bowel Management Standard stated:

If the resident did not have a bowel movement by the end of the 9th shift and/or based on their normal pattern, the resident will be assessed by a licensed nurse, which includes: bowel tones, abdominal distension, and pain. The bowel protocol will be initiated and if ineffective the physician will be notified for further instructions. The resident will remain on alert charting until resolution has occurred, new orders obtained,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 309	Continued From page 29 and care plan updated to reflect new interventions. On 2/22/16 at 10:21 AM, Physician M stated the facility should have provided the MOM and enema as requested by the resident. The orders for the medication are a part of the standing orders, and available at all times. Physician M continued and stated any time the resident requested a medication on the standings orders the nurse should assess the resident and administer the medication. Physician M continued and stated the resident was a very sick person by the time the hospital received him/her. The resident would have had decreased discomfort/pain and anxiety if he/she had been evaluated and treated earlier, although the resident had an abdominal mass and would have still probably needed to have a colostomy. The facility failed to thoroughly assess and provide timely interventions for Resident #1, who had nausea and vomiting, diarrhea, upset stomach, was hospitalized for a bowel obstruction, and required a colostomy.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 30	F 323		

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 60 residents. The sample included 4 residents. Based on observation, interview and record review, the facility failed to provide 3 of 3 sampled residents, with adequate supervision to prevent falls when staff failed to thoroughly assess for causative factors for 3 sampled residents and implement timely and appropriate interventions to prevent additional falls for 3 of 3 sampled residents. Resident #4, who required total assistance, sustained a wrist fracture after getting up at night to toilet independently. Resident #3 had multiple falls without intervention or a thorough root cause analysis to prevent further falls. Resident #2 sustained a shoulder injury after a fall and had a history of multiple falls without a thorough root cause analysis to prevent further falls.

Findings included:

- Resident #4's admission physician orders, dated 12/29/15, included Resident #4's diagnoses of multiple sacral (large triangular bone between the two hip bones) fractures, dementia (progressive mental disorder characterized by failing memory, confusion) with atypical psychosis (any major mental disorder characterized by a gross impairment in reality testing), and generalized weakness. The admission orders described the resident as incapable of making decisions, required total care, walked with assistance, full weight bearing, and experienced weakness. The physician ordered (PT) Physical therapy and (OT) Occupational therapy to evaluate and treatment as indicated for generalized weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 31	F 323		

The quarterly (MDS) Minimum Data Set assessment, dated 10/18/15, stated the resident had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 8, with verbal behaviors toward others, required limited assistance of 1 staff for bed mobility, dressing, and hygiene. The MDS stated the resident required supervision of transfers by 1 staff and was independent with walking in his/her room, the hallways, and with toileting. The assessment stated the resident's balance was unsteady with transfers, standing, walking, and toileting. The assessment further stated the resident could regain his/her balance without assistance. The resident used a wheeled walker and had 1 fall since the last assessment.

The readmission MDS, dated 1/5/16, revealed the resident was admitted from an acute care hospital, had moderately impaired cognition with a (BIMS) Brief Interview of Mental Status score of 9, verbal behaviors, required extensive assistance of 2 persons for (ADLs) Activities of Daily Living, his/her balance was unsteady and he/she required physical assistance from staff to rebalance. The MDS indicated the resident had a urinary catheter and an ostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body) bag, received antidepressant and antibiotic medications, had 1 fall with injury after readmission, 12 falls with injury in the month prior to readmission, and worked with PT and OT.

The cognitive loss (CAA) Care Area Assessment, dated 1/11/16, stated the resident had dementia, was confused at times and needed reoriented by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 32	F 323		

staff.

The fall CAA, dated 1/11/16, indicated PT and OT worked with the resident to gain strength and the resident participated in the walk to dine program, walking short distances with a gait belt, and the assistance of 1-2 staff.

The Morse Fall scale, dated 12/29/15, indicated the resident a high risk for falls with a score of 90. (A score greater than 45 degrees is considered high risk).

The 10/24/15 care plan, directed staff to provide a feather lite walker and 1 staff assistance, with a gait belt for ambulation in his/her room and the hallways. The care plan further directed staff to ensure shoes were comfortable and not slippery, or gripper socks were on his/her feet when walking. The care plan directed staff to obtain PT and/or OT to evaluate and provide treatment as needed. The 1/18/16 care plan update instructed staff to provide 1-2 staff assistance for ambulation, with a gait belt. The 1/20/16 care plan update directed staff to complete hourly safety checks are completed, and to apply a bed alarm.

The 1/25/16 care plan (4 days after readmission), directed staff to provide a wheelchair for activities outside of his/her room, and the resident required assistance from 1 staff to propel the wheelchair.

Review of the medical record revealed staff had not completed a 3 day bladder diary as a part of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 33	F 323		

the MDS assessment.

The 11/19/15 fall investigation report stated staff found the resident in the bathroom lying on the floor, one slip grip sock on his/her right foot, underneath a puddle of urine. Injuries resulting from the fall were multiple sacral fractures. The staff educated the resident to use the call light and ensure slip grips socks are on with all transfers.

The 1/17/16 at 12:01 AM, progress notes indicated staff entered the resident's room and found him/her sitting on the floor in the bathroom, with his/her back and head in the corner, call light not on. The note further indicated the resident stated he/she attempted to go to the bathroom without staff assistance. Staff last checked on the resident at 11:05 PM, and the resident rested quietly in bed. The note indicated the resident complained of pain to his/her head, left hand, hip, and upon standing the resident's left leg turned outward. The note further indicated staff received a physician's order to transfer the resident to the emergency room for evaluation and treatment. Review of the incident revealed the physician admission order directed staff to provide assistance of 1 for ambulation, as the resident could not make safe decisions.

The 1/17/16, X-ray evaluation revealed the resident had a radial fracture (broken arm bone) to his/her left arm/wrist.

The 1/18/16 (untimed), progress note revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 34	F 323		

the nurse indicated the root cause analysis of the fall was due to the resident's impaired cognitive function, the resident did not recognize his/her limitations, and was not oriented to reality. The note further indicated the resident required physical assistance with transfers and ambulation, did not use his/her call light for assistance, and did not wait until staff could help him/her. The note indicated staff reviewed the care plan.

On 2/9/16 at 9:31 AM, observation revealed Nurse Aide F and Nurse Aide G assisted the resident to transfer from a lying to a sitting position. Further observation revealed staff applied a gait belt, and with one staff on each side of the resident, cued him/her to stand, placed the wheeled walker in front of the resident, without locking the brakes. Continued observation revealed staff lifted a large portion of the resident's weight, using the gait belt, and provided stability for the resident to stand. The resident legs appeared slightly forward, with his/her upper body bent minimally at the waistline. The pressure from the resident's body weight caused his/her walker to move slightly, and the resident stated his/her feet were slipping. Further observation revealed the resident's feet did not slip with the gripper socks on, he/she walked forward, requiring staff to maintain balance for the resident as he/she walked to the toilet in the bathroom. Observation revealed the resident turned too early to sit down on the toilet seat, and voiced being tired. Staff continued with the transfer, but did not stop or offer the resident a wheelchair. Nurse Aide G quickly cued the resident to move to the left, but the resident did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 35	F 323		

not follow instructions, sat on the toilet riser arm rest, and Nurse Aide G moved the resident hips to the commode seat.

On 2/8/16 at 10:49 PM, Nurse D verified the resident transferred and walked independently in his/her room with a wheeled walker following admission from his/her prior hospital stay (11/19/15 to 12/29/15), and verified the resident's mobility status did not change. Nurse D further verified at times the resident did use the call light to request assistance, and staff assisted him/her with personal cares.

On 2/8/16 at 11:38 PM, Nurse Aide J verified on 1/17/16, staff found the resident on the bathroom floor, with his/her feet up, and no gait belt around the resident's waist, and the call light not on. Nurse Aide J stated further verified the staff should accompany the resident into the bathroom, with his/her wheeled walker. Nurse Aide J verified the resident had increased confusion at night, and occasionally used the call light system to request for staff assistance.

On 2/9/16 at 9:31 AM, Nurse Aide G stated the resident remained independent with transfers and walking after he/she returned to the nursing home following his/her last hospital stay (11/19/15 - 12/29/15). Nurse Aide G verified staff assisted the resident if he/she used the call light for assistance.

On 2/9/16 at 3:20 PM, Nurse I verified the facility did not complete 3 day bladder assessment as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 36	F 323		

part of the MDS assessment process, or as required by the facility's policy. Nurse I stated another nurse interviewed staff and asked questions about the time frames the resident toileted and then developed a care plan based on the staff response. Nurse I further verified a 3 day bladder assessment provided a better picture of the resident's toileting, mobility, and safety needs, and would assist staff to prevent falls.

On 2/9/16 at 3:20 PM, Administrative Nurse A verified the facility did not use the 3 day bladder assessment, and verified staff are expected to update the resident's care plan after a fall, on admission/readmission, and with any change in health status. Administrative Nurse A further verified the resident's need to use the bathroom could have contributed to his/her falls, and had not been assessed by the facility.

The 11/1/2011 Bowel and Bladder Management policy instructed staff a scheduled toileting plan must be included in each resident's care plan and directed staff to follow a scheduled toileting plan, document the care plan intervention provided, scheduled times each day, where staff is to toilet the resident, give the resident a urinal or bed pan, or remind the resident to go to the toilet. The policy directed staff to do an assessment upon admission, with a change in bowel or urinary habits, staff initiate a bowel monitoring record, which is documented for 3 days, and assisted to establish a resident's individual bowel and urinary pattern.

The facility's 1/4/2013 Fall Documentation policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 37	F 323		

instructed staff to document all falls for the purpose to identify root causes of the falls, to determine effectiveness of interventions, and track trends and injuries from the falls to safely maintain and/or to improve the resident's mobility and to minimize injury. The policy further directed staff the charge nurse is to update the care plan with interventions that are appropriate to prevent further falls.

On 2/18/16 at 11:28 AM, Physician M stated the resident was alert, but not oriented, and could not make safe decisions. Physician M further stated the resident required assistance of 1 staff for transfers and mobility, and stated his/her care plan needed to be revised on the day of admission.

The facility failed to provide Resident #4 with adequate supervision to prevent falls, when staff failed to thoroughly assess for causative factors for falls and implement appropriate interventions to prevent additional falls, and the resident fell during the night, attempting to toilet, and sustained a wrist fracture.

- Resident #2's annual (MDS) Minimum Data Set assessment, dated 1/17/16, indicated the resident had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 10, required limited assistance from staff for dressing and bathing, and was independent with his/her other (ADLs) Activities of Daily Living. The MDS further indicated the resident's balance was unsteady, although he/she could rebalance his/herself, had occasional incontinence of urine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 38	F 323		

and bowel, no trial toileting program, shortness of breath with exertion, participated 6 days on a restorative program for range of motion and communication, and had 2 non-injury falls wince the prior assessment.

The Falls (CAA) Care Area Assessment, dated 1/15/15, indicated the resident had a history of falling when he/she went to the bathroom. The CAA further verified the resident fell to seek attention, and knew if he/she fell a nurse would come down to see him/her. The CAA indicated the resident used a walker, had a bed alarm for nighttime use, and staff cued the resident to focus on walking when he/she was up to limit the risk for falling.

The 1/29/15 care plan instructed staff to remind the cognitively impaired resident to use his/her call light for staff assistance, and to remind the resident to be alert and careful when he/she walked through a congested area. The care plan further directed staff to encourage the resident to keep his/her bedside table at the foot of the bed, while in recliner, and educate the resident to maintain a clutter free environment. The care plan directed staff to review safety hazards around the resident's room, floor, and furniture. The care plan informed staff when the resident is upset he/she does not pay attention to safety hazards or surroundings. The care plan instructed staff to educate the resident on the importance of making slow position changes, and to remind the resident to wear gripper socks or shoes over plain socks.

The 2/3/16 care plan stated the resident walked independently with a wheeled walker, received restorative therapy for range of motion, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 39	F 323		

directed staff to monitor for side effects of medications related to dizziness. The care plan further directed staff to cue the resident to use the bathroom prior to meals, and may use a wheelchair in place of walking due to the resident's right arm in a sling.

The Morse Fall Scale, dated 1/7/15, indicated the resident at high risk for falling.

Review of the medical record revealed no 3 day bladder assessment to assess for voiding patterns.

Review of the medical record revealed the resident had falls related to bathroom use.

The 6/24/15 fall investigation report stated staff found the resident seated on the floor in his/her room. The resident had sneakers on, pants pulled around his/her waist, with the walker outside the bathroom door, the alarm not turned on, and it did not sound. The root cause analysis stated the resident lost his/her balance when he/she tried to pull his/her pants up. The staff failed to turn on the alarm notifying staff the resident was up. Staff reviewed the care plan, but lacked completion of a 3 day bladder diary to develop the care plan, to ensure the resident receives assistance. The report revealed the staff discontinued the alarm, but lacked a date that was done..

The 10/24/15 fall investigation report staff found the resident lying on the floor between the bathroom door and the recliner. The light was off, with the walker across the room, and regular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 40	F 323		

socks on. The resident reported he/she slipped and fell on the way back from the bathroom. Staff assessed the resident for injury, none found, and reviewed the pajama pants, but not the use of regular socks. The nurse did not complete a 3 day bladder diary to develop the care plan, to ensure the resident receives assistance.

The 1/21/16 at 2:30 PM, progress notes revealed the physician evaluated the resident for right shoulder pain, and the X-ray report indicated the resident had a mild irregularity of the non-displaced clavicle (shoulder), suggestive of a fracture. The note further indicated the physician ordered staff to place a sling on the resident's right arm.

The 2/8/16 fall investigation report stated staff found the resident seated on the floor, walker in front of him/her, and the call light was pushed after the resident slid to the floor. The resident stated he/she stood to use the bathroom, his/her knee gave out and he/she slid down the side of the bed. Staff completed a physical assessment, and raised the resident off the floor with assistance of 2 staff with a gait belt and walker. The nurse failed to utilize a 3 day bladder diary to develop the care plan, to ensure the resident receives assistance.

The 2/19/16 X-ray report revealed no fracture, dislocation or abnormality of the resident's unilateral clavicle.

On 2/9/16 at 1:06 PM, observation revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 41	F 323		

Nurse Aide K assisted the resident to transfer from the wheelchair to the recliner. Continued observation revealed staff did not apply a gait belt, and provided stand by assistance. Further observation revealed as the resident seated him/herself, his/her body twisted in the chair seat and Nurse Aide K cued the resident to pivot his/her body in the chair for proper positioning.

On 2/8/16 at 3:28 PM, the resident stated he/she had fallen in the bathroom, and stood back up on his/her own. The resident further verified the walker slid to the side and he/she lost his/her balance. The resident indicated staff assisted him/her to the bathroom currently, when he/she uses the call light.

On 2/9/16 at 3:23 PM, Nurse Aide K verified the resident walked independently, prior to the fall when he/she injured his/her shoulder. Nurse Aide K further verified the resident used a wheelchair, after the resident unsuccessfully tried to grasp the walker with his/her injured shoulder and arm, and walk. Nurse Aide K stated the resident experienced pain and had difficulty hanging onto the walker.

On 2/9/16 at 3:20 PM, Nurse I verified the facility did not complete 3 day bladder assessment as a part of the MDS assessment process, or as required by the facility's policy. Nurse I stated another nurse completed interviews with the staff about the time frames the resident toileted and a toileting care plan was developed based on the staff response to the questions. Nurse I further verified a 3 day bladder assessment provided a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 42	F 323		

better picture of the resident's toileting, mobility, and safety needs, and would assist staff to prevent falls.

On 2/9/16 at 3:20 PM, Administrative Nurse A verified the staff are expected to update the resident's care plan after a fall, on admission/readmission, and with any change in health status. Administrative Nurse A further verified the staff had not assessed the resident's voiding pattern with a 3 day bladder assessment and the resident's need to use the bathroom could have contributed to his/her falls.

The facility's 11/1/2011 Bowel and Bladder Management policy instructed staff a scheduled toileting plan must be included in each resident's care plan and directed staff to follow a scheduled toileting plan, document the care plan intervention provided, scheduled times each day, where staff is to toilet the resident, give the resident a urinal or bed pan, or remind the resident to go to the toilet. The policy directed staff to do an assessment upon admission, with a change in bowel or urinary habits, staff initiate a bowel monitoring record, which is documented for 3 days, and assisted to establish a resident's individual bowel and urinary pattern.

The facility's 1/4/2013 Fall Documentation policy instructed staff to document all falls for the purpose to identify root causes of the falls, to determine effectiveness of interventions, and track trends and injuries from the falls to safely maintain and/or to improve the resident's mobility and to minimize injury. The policy further directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 43	F 323		

staff the charge nurse is to update the care plan with interventions that are appropriate to prevent further falls.

The facility failed to provide adequate supervision to prevent falls, and utilize the root cause analysis, including a 3 day bladder assessment after Resident #2 had falls attempting to independently toilet, resulting in a fall injuring his/her right shoulder.

- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 5/28/15, revealed the resident had severely impaired cognition with a (BIMS) Brief Interview of Mental Status score of 5, required extensive assistance from 1-2 staff for (ADLs) Activities of Daily Living, not on a bladder or bowel toileting program, and was frequently incontinent of bowel and bladder. The MDS further indicated the resident had 1 non-injury fall since the last assessment.

The ADL (CAA) Care Area Assessment, dated 12/1/15, stated the resident required assistance of 2 staff, and a gait belt, for toileting. The CAA further indicated staff to provide short commands, for the resident to understand, and to provide assistance with cares.

The 12/11/15 care plan directed staff to walk the resident with 1 staff assistance, use a gait belt, a walker, provide a wheelchair for long distances, and provide extensive assistance to turn and reposition in bed, transfers, and toilet. The care plan directed staff to accompany the resident in the bathroom at 7:30 AM, 11:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, 9:00 PM, and 2:00 AM/5:30 AM (if awake). The care plan further directed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 44	F 323		

to ensure shoes are comfortable and not slippery, and to seat the resident in his/her recliner between meals.

The Morse Fall Scale, dated 5/23/15, indicated the resident at a high risk for falls, with a score of 75. The Morse Fall Scale instructions stated any score greater than 45 should be considered a high risk for falls. The medical record revealed staff assessed the resident a high fall risk on 6/9/15, 8/10/15, 8/20/15, 8/25/15, 11/28/15, 11/29/15, 12/17/15, 12/30/15, 1/28/15, and 2/8/16.

Review of the medical record revealed a 3 day bladder assessment had not been completed as a part of the MDS assessments.

The medical record revealed the resident had several falls related to bathroom use and/or incontinence and falls in his/her room. The medical record further revealed the nurse notified the physician and responsible party about the incidents, but did not make a long term care plan intervention after each fall to help prevent future falls.

The 8/10/15 fall investigation report revealed staff found the resident seated on the floor with his/her legs bent, feces on the floor behind him/her, and the resident stated he/she slipped trying to go to the bathroom. The nurse identified the resident incontinence of stool as the root cause. Staff reviewed the care plan and initiated an intervention to toilet the resident between 4:00 and 5:00 PM, due to urgency with bowel and bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 45	F 323		

The 8/20/15 fall investigation report revealed staff found the resident on the floor, seated upright, incontinent of stool, and the alarm had not sounded. The resident stated he/she attempted to go to the bathroom. The root cause stated the resident did not remember he/she could not get up to the bathroom unassisted. Staff reviewed the care plan and initiated an intervention to toilet the resident, after meals, to prevent incontinence.

The 11/29/15 fall investigation report revealed staff found the resident lying face down in his/her room, was incontinent of stool, and had a 3 (cm) centimeter x 2 cm hematoma (solid swelling of clotted blood within the tissues) to his/her left forehead. The root cause revealed the resident becomes anxious to go to the bathroom when he/she has diarrhea, required more supervision at that time, and needed to be in the wheelchair to allow the resident to be assisted to the bathroom faster.

The 12/17/15 fall investigation report revealed the staff found the resident in his/her room, face down on the floor, with urine noted on the floor. The resident reported he/she rolled out of bed. The care plan was reviewed and the staff were encouraged to toilet the resident before 4:00 PM and to place a mat on the floor beside the bed.

The 12/30/15 fall investigation report revealed staff found the resident lying on his/her left side in the bathroom, with his/her pants and attends pads wrapped around his/her knees, and gripper socks on. The resident stated he/she hit his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 46	F 323		

head and had a small bump to the left back side of the head. The resident stated he/she fell off the toilet. The root cause revealed the CNA had left the resident alone on the toilet, when the CNA should not have left the resident's side, since the resident could not use the call light for assistance. Staff reviewed the care plan and initiated an intervention for staff to not leave the resident alone on the toilet in his/her room, due to the high fall risk.

The 1/28/16 fall investigation report revealed staff found the resident seated on the floor in front of the television in the east lounge area. The nurse assessed the resident and found no injury. Staff transferred the resident to a wheelchair and assisted him/her to the snack bar area. Review of the video camera revealed the resident became restless and scooted to the edge of the chair and lowered him/herself to the floor. Staff observed the resident when he/she was restless in the recliner, and then would place in the wheelchair and take to the east television room for closer monitoring.

On 2/8/16, the physician order sheet, directed staff to perform hourly visual checks to ensure the resident safety.

On 2/9/16 at 3:20 PM, Nurse I verified the facility did not complete 3 day bladder assessment as a part of the MDS assessment process, or as required by the facility's policy. Nurse I stated another nurse completed interviews with the staff about the time frames the resident toileted and a toileting care plan was developed based on the staff response to the questions. Nurse I further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 47	F 323		

verified a 3 day bladder assessment provided a better picture of the resident's toileting, mobility, and safety needs, and would assist staff to prevent falls.

On 2/9/16 at 3:20 PM, Administrative Nurse A verified the facility did not use the 3 day bladder assessment, and verified staff are expected to update the resident's care plan after a fall, on admission/readmission, and with any change in health status. Administrative Nurse A further verified the resident's need to use the bathroom could have contributed to his/her falls, and had not been assessed by the facility.

The 11/1/2011 Bowel and Bladder Management policy instructed staff a scheduled toileting plan must be included in each resident's care plan and directed staff to follow a scheduled toileting plan, document the care plan intervention provided, scheduled times each day, where staff is to toilet the resident, give the resident a urinal or bed pan, or remind the resident to go to the toilet. The policy directed staff to do an assessment upon admission, with a change in bowel or urinary habits, staff initiate a bowel monitoring record, which is documented for 3 days, and assisted to establish a resident's individual bowel and urinary pattern.

The facility's 1/4/2013 Fall Documentation policy instructed staff to document all falls for the purpose to identify root causes of the falls, to determine effectiveness of interventions, and track trends and injuries from the falls to safely maintain and/or to improve the resident's mobility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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) COMPLETION DATE
F 323	Continued From page 48 and to minimize injury. The policy further directed staff the charge nurse is to update the care plan with interventions that are appropriate to prevent further falls. The facility failed to ensure staff completed a thorough assessment, including the 3 day voiding diary, and utilize the root cause analysis to develop care plan interventions for Resident #3, who had falls related to the need to toilet.	F 323		