STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N064002	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNCIL GROVE ASSISTED LIVING	554 COUNTRY LANE COUNCIL GROVE, KS 66846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a licensure resurvey with complaints (88383, 89944, 92169 and 95620) at the above named assisted living facility in Council Grove on 4/13/16, 4/14/16 and 4/18/16.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 16 residents. The sample included 3 residents. Based on record review, observation and interview for 2 (#414 and #415) sampled residents requiring health care services, the operator failed to ensure that a licensed nursed provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #414 recorded admission date of 10/20/14 with diagnoses of cerebral vascular accident, slurred speech, weakness, ataxia, diabetes type two, renal	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N064002	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNCIL GROVE ASSISTED LIVING	554 COUNTRY LANE COUNCIL GROVE, KS 66846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3155	Continued From page 1	S3155		

insufficiency, anemia, hypertension, gastroesophogeal reflux disease, osteoarthritis of right knee and depression.

Functional capacity screen (FCS) dated 10/9/15 recorded resident requires assistance with bathing, dressing, toileting, transfers and walk/mobility and as unable to perform management of medications and treatments. Resident recorded as having a history of falls/unsteadiness and impaired vision and difficulty with communication.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/9/15 recorded resident to receive staff assistance with bathing, personal hygiene, dressing, toileting, transfers and mobility and has had one fall.

Observation on 4 /14/16 at 11:00am during interview with resident in his/her room revealed 2 half side rails in the middle of resident ' s bed, both covered with a white netting cover. Resident stated " my son wanted me to have those so I don ' t roll out of bed again. They put them up at night. " Noted resident to have difficulty speaking with slurred speech and hard of hearing, (questions needed to be repeated several times).

Interview on 4/14/16 at 1pm with licensed staff #A confirmed the NSA/HCSP does not address resident is hard of hearing and has 2 side rails on his/her bed as an intervention to prevent falling out of bed.

Record review for resident #415 recorded admission date of 12/10/15 with diagnoses of: hypertension, vitamin B12 deficiency, hypokalemia, pedal edema, adult diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N064002	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNCIL GROVE ASSISTED LIVING	554 COUNTRY LANE COUNCIL GROVE, KS 66846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3155	Continued From page 2	S3155		

mellitus, atrial fibrillation, osteoarthritis and chronic vertigo.

FCS dated 1/7/16 recorded resident requires assistance with bathing, toileting and transfers, is unable to perform dressing, walk/mobility and management of medications and treatments, has difficulty with decision making, has a history of falls/unsteadiness (resident is a potential fall risk but has not fallen), has impaired vision and impaired hearing.

NSA/ HCSP dated 1/7/16 recorded resident to receive assistance with personal hygiene, transfers and eating and is unable to perform/ requires full assistance with bathing, dressing, toileting, mobility and staff to administer all medication and treatments and has a potential for falls.

Observation on 4/14/16 at 11:15am during interview with resident in his/her room revealed resident to be extremely hard of hearing and wearing eyeglasses.

Interview on 4/14/16 at 1:00pm with licensed staff #A confirmed resident is able to perform part of his/her bathing and toileting and does not require full assistance as listed on the NSA/HCSP. Also confirmed resident #415 is extremely hard of hearing and must be spoken to on the right side only, has poor vision and requires assistance with eyeglasses and these are not addressed on the NSA/HCSP.

Interview on 4/14/16 at 1:00pm with licensed staff # A confirmed facility does not have a policy regarding side rail use, the facility has no safety/maintenance plan for side rails, and resident assessments have not been completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N064002	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNCIL GROVE ASSISTED LIVING	554 COUNTRY LANE COUNCIL GROVE, KS 66846

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3155	Continued From page 3 for use of side rails for resident #414 or any resident in the facility who has side rails attached to their beds. For residents #414 and #415, the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		