STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B067003	A. BUILDING: _____ B. WING _____	11/05/2015

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COUNTRY PLACE MEMORY CARE OF CHANUTE	705 OSA MARTIN BLVD CHANUTE, KS 66720

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey of the above home plus facility on 11/3/15, 11/4/15, and 11/5/15.	S 000		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)	S5028		

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

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S5028	Continued From page 1 The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1(#152) of 3 residents sampled, the operator failed to report to the department within 24 hours when a staff member found the cognitively impaired resident on the floor in order to rule out abuse and/or neglect. Findings included: - Record review for resident #152 revealed an admission date of 1/15/15 and diagnoses of dementia, congestive heart failure, atrial fibrillation, and hypertension. The functional capacity screen dated 4/17/15 and 8/6/15 indicated the resident was at risk for falls. Each functional capacity screen indicated the resident required physical assistance with bathing, toileting, transferring, mobility, and eating; was unable to dress self, manage medications and treatments; was incontinent of urine; experienced impaired short- term memory, long-term memory, decision making, and memory recall; experienced impaired vision and hearing; and exhibited wandering and socially inappropriate disruptive behavior. The negotiated service agreement/health care service plan dated 8/6/15 documented facility staff to assist resident with bathing, dressing, toileting, transferring, ambulation with walker or mobility with wheelchair; and administration of medications and treatments. The negotiated service agreement/health care service plan documented interventions related to the resident's risk for falls as clutter free room, gait belt when transferring, chair and bed alarm, non-skid footwear, keep items in reach of	S5028		

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S5028	Continued From page 2	S5028		

resident and resident likes to sit in sitting room to see/visit with other residents and staff.

The nurse's progress notes contained the following entries of a staff member finding the resident on the floor:

4/25/15 at 9:30 p.m. a licensed nurse documented resident removed alarm and fell.

5/22/15 at 10:00 a.m. a licensed nurse documented resident slid out of dining room chair.

7/8/15 licensed nurse #A documented resident rolled out of bed when repositioning self. Resident had redness to back of head.

7/13/15 licensed nurse #A documented at 6:00 a.m. staff member found resident on floor in resident's room. Resident to be moved to a room closer to nurse's office.

9/21/15 licensed nurse #A documented resident rolled out of bed when repositioning self at 3:00 a.m. Resident received bruising to face, right knee, right arm, and back.

Review of fall investigations revealed the following:

4/25/15 Resident (#152) fell at 9:03 p.m. while certified employee was giving another resident a shower. Resident (#152) was trying to get to bathroom and had removed alarm.

5/22/15 unwitnessed fall with staff member alerted by sound of alarm.

7/8/15 Resident's alarm sounded, staff member

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S5028	Continued From page 3 went to resident's room, and observed resident on floor. Licensed nurse #A documented resident rolled over and fell out of bed. 7/13/15 at 6:00 a.m. staff member heard alarm and found resident on floor by bed. Resident stated he/she rolled out of bed. 9/21/15 at 3:00 a.m. a staff member documented "Heard resident talking in (his/her) sleep, then words became muffled and I decided to check on (him/her) and (resident) was lying face first on the floor." The investigations did not indicate the operator or licensed nurse reported these incidents to the department. At 2:50 p.m. on 11/4/15, the operator confirmed he/she did not report to the department when a staff member found the resident on the floor. The operator failed to report to the department within 24 hours when a staff member found cognitively impaired resident #152 on the floor in order to rule out abuse and/or neglect.	S5028		
S5155 SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S5155		

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S5155	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1(#152) of 3 residents sampled, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident identified at risk for falls. Findings included: - Record review for resident #152 revealed an admission date of 1/15/15 and diagnoses of dementia, congestive heart failure, atrial fibrillation, and hypertension. The functional capacity screen dated 4/17/15 and 8/6/15 indicated the resident was at risk for falls. Each functional capacity screen indicated the resident required physical assistance with bathing, toileting, transferring, mobility, and eating; was unable to dress self, manage medications and treatments; was incontinent of urine; experienced impaired short- term memory, long-term memory, decision making, and memory recall; experienced impaired vision and hearing; and exhibited wandering and socially inappropriate disruptive behavior. The negotiated service agreement and health care service plan dated 8/6/15 documented the following interventions related to the resident's risk for falls: Clutter free room,	S5155		

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S5155	Continued From page 5	S5155		

Gait belt when transferring,
Chair and bed alarm,
Non-skid footwear,
Keep items in reach of resident,
Resident likes to sit in sitting room to see/visit with other residents and staff.

The negotiated service agreement/health care service plan dated 8/6/15 documented facility staff to assist resident with bathing, dressing, toileting, transferring, ambulation with walker or mobility with wheelchair; and administration of medications and treatments.

The nurse's progress notes contained the following entries:

4/25/15 at 9:30 p.m. a licensed nurse documented resident removed alarm and fell.

4/28/15 at 12:00 p.m. a licensed nurse documented staff witnessed resident reach for items on floor and resident fell.

5/12/15 a licensed nurse documented resident experienced a witnessed fall when transferring from bathroom to bed.

5/22/15 at 10:00 a.m. a licensed nurse documented resident slid out of dining room chair.

7/8/15 licensed nurse #A documented resident rolled out of bed when repositioning self. Resident had redness to back of head.

7/13/15 licensed nurse #A documented at 6:00 a.m. staff member found resident on floor in resident's room. Resident to be moved to a room closer to nurse's office.

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S5155	Continued From page 6 9/21/15 licensed nurse #A documented resident rolled out of bed when repositioning self at 3:00 a.m. Resident received bruising to face, right knee, right arm, and back. Review of fall investigations revealed the following: 4/25/15 Resident (#152) fell at 9:03 p.m. while certified employee was giving another resident a shower. Resident (#152) was trying to get to bathroom and had removed alarm. Intervention listed to keep alarm out of reach of resident, occupational and physical therapy, clutter free floor, toilet assistance, and appropriate shoes. No investigations provided for resident falls on 4/28/15 and 5/12/15. 5/22/15 unwitnessed fall with staff member alerted by sound of alarm. Interventions listed of change alarm to a pressure alarm, gait belt with transfers, occupational and physical therapy, and visual checks. 7/8/15 Resident ' s alarm sounded, staff member went to resident's room, and observed resident on floor. Licensed nurse #A documented resident rolled over and fell out of bed. Intervention of move resident closer to nurse's office. 7/13/15 at 6:00 a.m. staff member heard alarm and found resident on floor by bed. Resident stated he/she rolled out of bed. No new intervention documented. 9/21/15 at 3:00 a.m. a staff member documented "Heard resident talking in (his/her) sleep, then words became muffled and I decided to check on	S5155		

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S5155	Continued From page 7 (him/her) and (resident) was lying face first on the floor." Intervention documented by licensed nurse #A will obtain a hospital bed with side rails for positioning. At 11:45 a.m. on 11/4/15, when asked about interventions for the resident's risk for falls, licensed nurse #A stated a hospital bed with one side rail would help resident to reposition self and not fall out of bed. At 1:25 p.m. on 11/4/15, certified employee #B listed interventions implemented related to resident's risk for falls as use gait belt when transferring resident and resident to have a personal alarm on at all times. The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #152 identified at risk for falls.	S5155		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#152) of 3 residents sampled, the operator failed to ensure the health care service of neurological assessment was provided by qualified staff in accordance with	S5171		

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S5171	Continued From page 8 acceptable standards of practice. Findings included: - Record review for resident #152 revealed an admission date of 1/15/15 and diagnoses of dementia, congestive heart failure, atrial fibrillation, and hypertension. The functional capacity screen dated 4/17/15 and 8/6/15 indicated the resident was at risk for falls. Each functional capacity screen indicated the resident required physical assistance with bathing, toileting, transferring, mobility, and eating; was unable to dress self, manage medications and treatments; was incontinent of urine; experienced impaired short- term memory, long-term memory, decision making, and memory recall; experienced impaired vision and hearing; and exhibited wandering and socially inappropriate disruptive behavior. The negotiated service agreement/health care service plan dated 8/6/15 documented facility staff to assist resident with bathing, dressing, toileting, transferring, ambulation with walker or mobility with wheelchair; and administration of medications and treatments. The negotiated service agreement/health care service plan documented interventions related to the resident's risk for falls as clutter free room, gait belt when transferring, chair and bed alarm, non-skid footwear, keep items in reach of resident and resident likes to sit in sitting room to see/visit with other residents and staff. The nurse's progress notes contained the following entries of resident falling with injury to head:	S5171		

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S5171	Continued From page 9 7/8/15 licensed nurse #A documented resident rolled out of bed when repositioning self. Resident had redness to back of head. 9/21/15 licensed nurse #A documented resident rolled out of bed when repositioning self at 3:00 a.m. Resident received bruising to face, right knee, right arm, and back. 9/21/15 licensed nurse #A documented at 3:30 a.m. staff to do neurochecks. The record contained documentation by certified staff members on three "Neurological Flow Sheet" forms. The first form was initiated at 8:45 p.m. on 7/4/15 and ended at 11:30 a.m. on 7/5/15. The second form was initiated at 7:15 a.m. on 7/8/15 and ended at 10:00 a.m. on 7/10/15. The third form was initiated at 3:00 a.m. on 9/21/15 and ended at 5:00 a.m. on 9/22/15. The "Neurological Flow Sheet" contained instructions for an assessment of the resident's level of consciousness, ability to move extremities, quality of hand grasp, pupil size, and pupil reaction to light, quality of speech, and vital signs. The form documented the neurocheck to be performed every 15 minutes for 1 hour, every 30 minutes for 1 hour, every hour for 4 hours, and then every 4 hours for 24 hours. Each entry contained the initials of a certified staff member. Note: a neurological assessment (neurocheck) requires the judgment of a licensed nurse in order to determine signs and symptoms of increased intracranial pressure and the need to report findings to a medical care provider. At 11:45 a.m. on 11/4/15, licensed nurse #A stated he/she performed the first two neurochecks of the resident and then instructed	S5171		

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S5171	Continued From page 10 certified staff members to perform ongoing neurochecks. The operator failed to ensure the health care service of neurological assessment of resident #152 was provided by qualified staff in accordance with acceptable standards of practice.	S5171		