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COUNTRY PLACE SENIOR LIVING OF CLAY CENTER	722 LIBERTY CLAY CENTER, KS 67432

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S 000	INITIAL COMMENTS The following citations represent the findings of a licensure resurvey at the above named Assisted Living Facility in Clay Center, Kansas on 01/29/15 and 2/2/15. Revised 2567 mailed to facility on 2/3/15.	S 000		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The census equalled 18 the sample included three Residents. Based on interviews and reviews of records, for two of three sampled (#185 and #187), the Operator failed to ensure all health care services provided to Residents by qualified staff in accordance with acceptable standards of practice, in regard to the implementation of physician's orders. Findings included: - Review of record revealed #187 admitted to facility 3/28/14 with diagnoses of Dementia, Atrial fibrillation, and Pleural effusion. The current 3/28/14 functional capacity screen assessed #187 in need of physical assistance (2) with bathing and eating, and unable to perform (3) medication and treatment management. The current 3/28/14 negotiated service agreement (NSA) documented #187 to receive a "Regular" diet, with weekly weights as ordered, and assistance needed occasionally in opening	S3171		

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

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S3171	Continued From page 1	S3171		

cartons, cutting meat, etc.
The record contained a 9/15/14 physician's order for "Low Sodium (< 2 grams) diet."
The record contained a 9/15/14 Diet Order Form, that documented "Diet Change" and Diet Order of "Low Na+ (sodium) (<2 grams).
The NSA/Health Service Plan lacked this dietary change. The medical record lacked evidence the order implemented or discontinued by the physician.

By interview on 02/02/15 at 10:00am, Facility Nurse stated it was an oversight that the order was not placed on the NSA... we took the salt shaker away and just replace with salt substitute... could talk with the physician about a "No added salt" diet... that's really what we are doing... confirmed the original < 2 gram diet order not discontinued by the physician, and no clarification obtained.

By interview on 02/02/15 at 11:25am, Dietary Services Manager confirmed no written instructions by a Registered Dietician available for a < 2 gram Na diet... not following any specific diet... took the salt shaker off the table... we have salt substitute on the table... gets everything everyone else gets...

The Operator failed to ensure all health care services provided to #187 by qualified staff in accordance with acceptable standards of practice, in regard to the implementation and/or clarification and/or discontinuation of physician's orders.

- Review of record revealed #185 admitted to facility 6/25/14 with diagnoses of Parkinson's, Depression, Weight Loss, Peripheral neuropathy,

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S3171	Continued From page 2 and Chronic lymphoid leukemia. The current 6/25/14 functional capacity screen assessed #185 in need of physical assistance (2) with dressing and toileting, and unable to perform (3) medication and treatment management; with bladder incontinence, history of falls, and long term memory and memory recall impairments. The current 6/25/14 negotiated service agreement (NSA) documented #185 assisted with bathing and dressing: at time independent with toileting and in need of assistance with toileting when incontinent episodes. An NSA amendment of 7/28/14 implemented a 2 hour bowel and bladder program for Resident and to take #185 to the bathroom after each meal. An NSA amendment of 10/27/14 implemented Occupational therapy and Speech therapy, and a Parkinson's Program to help reduce fall risk. A physician's order of 10/06/14 documented "Bed alarm to prevent future falls." The Resident Progress Notes of 10/06/14 documented ...seen by physician... recommend bed alarm for Resident... spoke with family about them purchasing alarm if they want him/her to have one... The NSA/Health Service Plan lacked this fall prevention intervention. The medical record lacked evidence the order implemented or discontinued by the physician. By interview on 02/02/15 at 12:00pm the Facility Nurse stated the bed alarm order never implemented... not added to the NSA/Health Service Plan... not discontinued by the physician... our facility does not typically use alarms... no clarification obtained from the physician in regard to this order or the discontinuation of it...	S3171		

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S3171	Continued From page 3 The Operator failed to ensure all health care services provided to #185 by qualified staff in accordance with acceptable standards of practice, in regard to the implementation and/or clarification and/or discontinuation of physician's orders.	S3171		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The census equalled 18 the sample included three Residents. Based on interviews and reviews of records, for two of three sampled (#185 and #187), the Operator failed to ensure the Resident's record contained documentation of all incidents, symptoms, indications of illness, time of occurrence, action taken, and results of the action. Findings included: - Review of record revealed #185 admitted to facility 6/25/14 with diagnoses of Parkinson's, Depression, Weight Loss, Peripheral neuropathy, and Chronic lymphoid leukemia. The current 6/25/14 functional capacity screen assessed #185 in need of physical assistance (2)	S3261		

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with dressing and toileting, and unable to perform (3) medication and treatment management; with bladder incontinence, history of falls, and long term memory and memory recall impairments.
The current 6/25/14 negotiated service agreement (NSA) documented #185 assisted with bathing and dressing: at times independent with toileting and in need of assistance with toileting when incontinent episodes.
An NSA amendment of 7/28/14 implemented a 2 hour bowel and bladder program for Resident and to take #185 to the bathroom after each meal.
An NSA amendment of 10/27/14 implemented Occupational therapy and Speech therapy, and a Parkinson's Program to help reduce fall risk.
A physician's order of 10/06/14 documented "Bed alarm to prevent future falls."
The Resident Progress Notes of 10/06/14 documented ...seen by physician... recommend bed alarm for Resident... spoke with family about them purchasing alarm if they want him/her to have one...
The medical record lacked evidence the order implemented or discontinued by the physician.

By review, #185 experienced multiple falls. The medical record failed to include all details and follow-up care as required. The facility used various tools and logs to track and document incidents that were not a part of the Resident's medical record. Examples from the "Fall Intervention Plan" included:

6/26/14 - Residents phone set up today - will re-orient call button system
7/22/14 - Consider B & B (bowel and bladder) program for Resident
7/28/14 - Implement 2 hour B & B program. Take Resident to bathroom after meals.
8/01/14 - Encouraged leaving bathroom light on

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at night to help being able to see.
9/02/14 - Revise bedtime toileting schedule.
9/30/14 - Encouraged Resident to sit on toilet lid vs trying to make it to bed to sit.
10/13/14 - Resident in hospital for PT/OT (physical therapy/occupational therapy) evaluation to help decrease falls.
12/17/14 - Encouraged resident to call for staff to clean up any messes in bathroom.
01/19/15 - Reminded Resident to slow down and take "Big" steps.

In further review of these incidents, a "Resident Fall Log" maintained, a "Falls Management Investigation" completed (but not on all fall incidents), a "Resident Progress Note and/or a fax to the physician completed.
The Fall Log included all Residents of facility documented together on this tool. This Log not considered part of the Resident's legal record, and included columns titled: Name, Date, Time, Location, Result of Fall, and Intervention.
The Falls Management Investigation not completed on each incident, and included evaluation and assessment gathering of the facts and potential prevention planning.

By review:
Resident Progress Notes (RPN) - 6/26/14 - 1312 - Resident was up in night to urinate and slid out of a chair in room to the floor... no apparent injuries, moves all extremities without pain... family and physician notified. The record lacked a Falls Management Investigation. The Medical record lacked the time, actions taken, and results of the actions taken.
RPN - 7/22/14 - Resident called for help yesterday to say he/she had fallen... was heading to the bathroom and lost his/her step... was sitting and leaning against the wall and closet... denied

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pain after or dizziness prior to the fall... no apparent injuries... without pain... family and physician notified. The record lacked a Falls Management Investigation. The medical record lacked the time, actions taken, and results of the actions taken.
RPN - 7/28/14 - 1204 - Resident fell in room this morning... see fax to physician... Fax documented "fell this morning in room... unable to tell us exactly what happened... small skin tear to right outer ear...gauze and tape applied... moves all extremities, family notified... going to implement a 2 hour B & B program and take back to room after meals... offer assistance to bathroom...
The Falls Management Investigation form contained multiple blank areas. The Medical record lacked the time, and the results of the actions taken.
RPN - 9/02/14 - 1147 - fell early Saturday morning around 0300 on 8/30/14... was walking to bathroom and got feet and walker tangled up in bedding... no apparent injuries... family and physician notified...
The Falls Management Investigation form contained multiple blank areas. The Medical record lacked the time, and the results of the actions taken.
RPN - 9/30/14 - 1614 - fell this morning around 0945 in white after coming out of bathroom... underwear down to knees... was sitting on floor against the door jam and his right forehead... small 1 centimeter superficial laceration... family and physician notified. Moves all other extremities without pain.
The record lacked a Falls Management Investigation. The medical record lacked the actions taken, and results of the actions taken.
RPN - 10/13/14 - 1511 - Resident fell yesterday and this morning yesterday was coming out of

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bathroom and had pants still pulled down... received a bump to head... today ambulating with walker to dining room table and somehow fell hitting nose... bleeding and marks down nose and below bottom lip... to emergency room for evaluation... admitted... observed... broken nose...
The Falls Management Investigation form contained multiple blanks, and combined the two separate incidents and circumstances. The Medical record lacked the time, and the actions taken for each incident.
RPN - 12/17/14 - 1820 - was found on bathroom floor yesterday morning around 0955... see fax to physician... Fax documented "called for help yesterday morning around 0955... staff arrived found on bathroom floor... unable to tell us how it happened... was trying to clean self up from a bowel movement... moved all extremities without pain... family notified...
The Falls Management Investigation form contained multiple blank areas. The Medical record lacked the time, and the results of the actions taken.

By interview on 02/02/15 at 11:30am, Facility Nurse stated we use Incident Reports and daily "report sheets" to document falls... these are not stored in the medical record... Facility Nurse confirmed the "Resident Fall Log" contained a great deal of pertinent information, but was a compilation of all Residents and not suitable for each Resident's medical record... Facility Nurse confirmed the "Falls Management Investigations" not always complete and not always evident in the health service plan...

By interview on 02/02/15 at 3:30pm, the Operator stated all Incident Reports and Fall Investigation forms are reviewed and signed... I decide if

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S3261	Continued From page 8 immediate concerns are taken care of (have they been sent to hospital if necessary, etc) and then discuss with nurse if this a repeat situation, if it differs from prior incidents, anything in the room causing... we are reviewing for any neglect issues throughout this process... The Operator failed to ensure #185's record contained documentation of all incidents, symptoms, indications of illness, time of occurrence, action taken, and results of the action. - Review of record revealed #187 admitted to facility 3/28/14 with diagnoses of Dementia, Atrial fibrillation, and Pleural effusion. The current 3/28/14 functional capacity screen assessed #187 in need of physical assistance (2) with bathing and eating, and unable to perform (3) medication and treatment management. The current 3/28/14 negotiated service agreement (NSA) documented #187 to receive a "Regular" diet, with weekly weights as ordered, and assistance needed occasionally in opening cartons, cutting meat, etc. Resident Progress Notes (RPN) - 6/06/15 - fell early yesterday. See faxed note to physician... family notified... Fax documented Resident fell yesterday (Thursday) morning... found by bathroom door... says went to the bathroom but doesn't know what happened... had difficulty with balance after getting up and walking to be...was falling backwards several times... went back to bed and when got up balance was normal... denied pain... fine today also... By interview on 02/02/15 at 11:30am, Facility Nurse stated if a fall with no loss of consciousness or no injuries... they will call me in	S3261		

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S3261	Continued From page 9 the morning... if anything else they will call me right away and I am asking questions over the phone... if severe enough, will call the ambulance... Incident report completed but not kept in the medical record... confirmed no other documentation for time, actions taken, or results of action... The Operator failed to ensure #187's record contained documentation of all incidents, symptoms, indications of illness, time of occurrence, action taken, and results of the action.	S3261		