STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N080004	A. BUILDING: _____ B. WING _____	09/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF LYONS	502 S MILES ST LYONS, KS 67554

(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 at the above named Assisted Living Facility in Lyons, Kansas on 9/25/14, 9/29/14, and 9/30/14.	S 000		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The census equalled 12 the sample included three Residents. Based on observation, interview, and review of record, for two of three sampled (#187 and #185), the Operator failed to ensure the negotiated service agreement (NSA) contained a description of the health care services to be provided. Findings included: - Review of record revealed #185 admitted to facility 6/30/14 with diagnoses of Dementia, Osteoarthritis, Osteoporosis, Hyperlipidemia, Stent, Gastroesophageal reflux disease, Hypertension, and Hypothyroidism. The current 6/30/1 FCS (functional capacity screen) assessed #185 in need of physical assistance with bathing, dressing; in need of supervision with eating; unable to perform medication and treatment management; and "4" for cognitive status with short term and long term	S3165		

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

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S3165	Continued From page 1	S3165		

memory deficits, impaired memory recall and impaired decision making; communication that is sometimes understood and he/she is sometimes understandable.
The current 6/30/14 NSA/HSP (negotiated service agreement/health service plan) documented facility staff to assist with bathing, dressing; provide medication and treatment management; supervise eating; and remind of meal times and activities.
The medical record contained an admission History and Physical Examination of 7/01/14. The physician's assessment of #185 documented a concern that #185 may become confused and wander off... may potentially require placement in more of a "wanderguard present" facility.

On 9/25/14 at 10:00am, Operator #G stated one Resident #185 who tends to leave... dementia... will leave and go to neighbor's... neighbor brought back... we have an alarm mat at the door that is periodically on... we turn it on when things get busy...

On 9/25/14 at 10:50am, CMA (certified medication aide) #B stated yes #185 still goes out... most recent was 4:30am Tuesday... out the front door... staff told him/her how early it was and offered cup of coffee and brought #185 back inside... seems to be "Sundowner's"...

By review, the medical record and the NSA/HSP lacked any documentation of #185 leaving facility without staff knowledge. The record lacked any further assessment of #185's dementia and cognitive status. The record lacked planned interventions to ensure #185's safety and whereabouts.

On 9/25/14 at 5:14pm, Operator #G and CMA #B

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S3165	Continued From page 2 confirmed nothing in the NSA/HSP for interventions... #G and #B stated occurrence as recent as 9/23/14... staff in the laundry room heard alarm mat at front door ... saw #185 outside with coat and purse... told him/her what time it was... back inside... Operator #G and CMA #B stated in the beginning it was two or three times per week... would go to friend's house about a block away... friend would bring #185 back... staff would remind #185 to sign out... didn't always know #185 was gone... knew he/she went visiting and we would remind about meal time and temperature outside... is now more settled and doesn't leave any more... with exception of Tuesday morning (9/23/14)... On 9/29/14 at 3:20pm Facility Licensed Nurse #E stated on 9/23/14 friend/neighbor returned #185 to facility about supper time... staff not aware he/she was gone... not gone long... another time the friend called to say #185 there... on Wednesday (9/24/14) at 3:30am #185 was dressed and headed out to leave... CMA on duty reminded him/her it was dark outside, talked into coming back inside and had a cup of coffee... Facility Licensed Nurse #E confirmed no documentation available for these symptoms of disorientation and potential wandering or elopement, and nothing in the NSA/HSP... #E stated I was on vacation last week and did not know about the incident or document it (9/24/14 at 3:30am)... did not document other situations... #E stated unable to provide other dates, times, or circumstances of when Resident "went visiting" unknown to staff... using alarm mat and first one hour checks, now 30 minute checks, but these not planned/documented interventions and no way of monitoring checks done or the effectiveness...	S3165		

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S3165	Continued From page 3 The Operator failed to ensure the NSA/HSP for #185 contained a description of the health care services to be provided, in regard to symptoms of dementia, impaired decision making, disorientation, and a potential for wandering or elopement. - Review of record revealed #187 admitted to facility 3/01/13 with diagnoses of Diabetes mellitus, Atrial fibrillation, Coronary artery disease, Gastroesophageal reflux disease, Depression, and Hypertension. The current 02/26/14 FCS (functional capacity screen) assessed #187 independent with bathing, dressing, toileting, transfers, mobility, eating; unable to perform medication and treatment management; with short term memory impairment; and with falls/unsteadiness. The current 02/26/14 NSA/HSP (negotiated service agreement/health service plan) documented facility staff to manage medications and #187 to self inject insulin under staff supervision. The current NSA/HSP documented #187 independent with transfers and mobility. Resident Notes of medical record and fax communications with physician documented multiple "falls" or incidents of #187 sliding to floor from couch. The Resident Notes documented staff frequently reminded #187 to call for assistance, and documented the use of alarms on #187's chair and bed in room, to allow staff to assist #187 to prevent falls due to unsteadiness. The NSA/HSP lacked interventions related to staff assistance and lacked interventions related to the use of alarms. On 9/29/14 at 2:45pm, Facility Licensed Nurse #E	S3165		

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S3165	Continued From page 4 stated #187 returned from the hospital on 8/05/14 with a need for assistance due to weakness and unsteadiness... we completed a new FCS and NSA/HSP to include alarms and assistance... this not in the record because when presented to family members, they requested to "think about the changes" which would change #187's level of care, before signing... the record still contains the FCS and NSA in place before hospitalization and these lack the need for different interventions... we are using alarms and reminding #187 to call us for assistance when getting up or walking even though not reflected in the NSA/HSP... The Operator failed to ensure the NSA/HSP for #187 contained a description of the health care services to be provided, in regard to physical assistance for transfers and mobility to prevent falls due to unsteadiness and the use of alarms to prevent falls.	S3165		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall	S3215		

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S3215	Continued From page 5 have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The census equalled 12 the sampled included three Residents. The roster identified one Resident who used insulin and Resident included in the sample. Based on observation, interview, and review of record, for one of one sampled who used insulin (#187), the licensed nurses and medication aides failed to ensure insulin pens stored in accordance with manufacturer's recommendations. Findings included: - By observation on 9/25/14 at 10:40am in the medication storage room of facility, licensed nurses and medication aides stored insulin pens in the refrigerator of the medication room. The refrigerator contained a prescription box with	S3215		

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S3215	Continued From page 6	S3215		

unopened insulin pens inside (Novolog Mix 70/30). The same refrigerator shelf contained a paper towel with an open and in use insulin pen laying on the paper towel. The insulin pen lacked a name or date opened for use.

On 9/25/14 at 10:40am, CMA (certified medication aide) #B stated the insulin pen is for #187... confirmed the open insulin pen lacked a date opened, and confirmed the opened pens always stored in the refrigerator with the unopened... stated not aware of the need to store opened insulin pen at room temperature.

By review on 9/25/14, the manufacturer's package insert directed the storage of unopened pens in the refrigerator. The package insert instructed: "Keep at room temperature below 86 degrees Fahrenheit for up to 14 days... Do Not store a Novolog Mix 70/30 pen that you are using in the refrigerator."

Review of record revealed #187 admitted to facility 3/01/13 with diagnoses of Diabetes mellitus, Atrial fibrillation, Coronary artery disease, Gastroesophageal reflux disease, Depression, and Hypertension. The September 2014 MAR (medication administration record) documented the use of Novolog 70/30 insulin twice daily. The current 02/26/14 FCS (functional capacity screen) assessed #187 unable to perform medication and treatment management. The current 02/26/14 NSA (negotiated service agreement) documented facility staff to manage medications and #187 to self inject under staff supervision.

On 9/29/14 at 2:31pm, Facility Licensed Nurse #E confirmed the insulin pens stored inappropriately and not labeled with date opened... stated the

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S3215	Continued From page 7 Resident uses the contents of the entire pen within ten days, so the insulin has not been used past the 14 recommended days. The licensed nurses and medication aides failed to ensure insulin pens for #187 stored in accordance with manufacturer's recommendations.	S3215		
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 12 the sample included three Residents. Based on observation, interview, and review of record, for one of three sampled (#185), 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 6/30/14 with diagnoses of Dementia, Osteoarthritis, Osteoporosis, Hyperlipidemia, Stent, Gastroesophageal reflux disease,	S3261		

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S3261	Continued From page 8	S3261		

Hypertension, and Hypothyroidism.
The current 6/30/1 FCS (functional capacity screen) assessed #185 in need of physical assistance with bathing, dressing; in need of supervision with eating; unable to perform medication and treatment management; and "4" for cognitive status with short term and long term memory deficits, impaired memory recall and impaired decision making; communication that is sometimes understood and he/she is sometimes understandable.
The current 6/30/14 NSA/HSP (negotiated service agreement/health service plan) documented facility staff to assist with bathing, dressing; provide medication and treatment management; supervise eating; and remind of meal times and activities.
The medical record contained an admission History and Physical Examination of 7/01/14. The physician's assessment of #185 documented a concern that #185 may become confused and wander off... may potentially require placement in more of a "wanderguard present" facility.

On 9/25/14 at 10:00am, Operator #G stated one Resident #185 who tends to leave... dementia... will leave and go to neighbor's... neighbor brought back...

On 9/25/14 at 10:50am, CMA (certified medication aide) #B stated yes #185 still goes out... most recent was 4:30am Tuesday... out the front door... staff told him/her how early it was and brought #185 back inside... seems to be "Sundowner's"...

By review, the medical record and the NSA/HSP lacked any documentation of #185 leaving facility without staff knowledge. The record lacked any further assessment of #185's dementia and

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S3261	Continued From page 9	S3261		

cognitive status. The record lacked planned interventions to ensure #185's safety and whereabouts.

On 9/25/14 at 5:14pm, Operator #G and CMA #B confirmed no documentation available... stated on Tuesday morning staff in the laundry room heard the alarm mat at front door sounding... saw #185 outside with coat and purse... told him/her what time it was... Operator #G and CMA #B stated in the beginning it was two or three times per week... would go to friend's house about a block away... friend would bring #185 back... staff would remind #185 to sign out... didn't always know #185 was gone... knew he/she went visiting and we would remind about meal time and temperature outside... is now more settled and doesn't leave any more... with exception of Tuesday morning (9/23/14)...

On 9/29/14 at 3:20pm Facility Licensed Nurse #E stated on 9/23/14 friend/neighbor returned #185 to facility about supper time... staff not aware he/she was gone... not gone long... another time the friend called to say #185 there... on Wednesday (9/24/14) at 3:30am #185 was dressed and headed out to leave... CMA on duty reminded him/her it was dark outside, talked into coming back inside and had a cup of coffee... Facility Licensed Nurse #E confirmed no documentation available for these symptoms of disorientation and potential wandering or elopement. #E stated I was on vacation last week and did not know about the 9/23 - 9/24 incident or document it... do not know how many times not documented. #E stated unable to provide other dates, times, or circumstances of when Resident "went visiting" unknown to staff.

The Operator failed to ensure #185's record

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S3261	Continued From page 10 contained documentation of all incidents, symptoms, indications of illness, time of occurrence, action taken, and results of the action.	S3261		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e)(1) The census equalled 12 the sample included three Residents. The facility provided meal services to all Residents. Based on observation, interview, and review of record, for one of one kitchen tour observation, the Operator failed to ensure facility staff stored all food under safe and sanitary conditions, and in accordance with facility policy and procedure, for thawing of potentially hazardous foods. Findings included: - On 9/25/14 at 11:05am, in the kitchen of facility, during tour accompanied by Operator, observed three packages of frozen pork shops in the sink of preparation island next to the refrigerator. The packages were sitting in a dry sink, without running water. On 9/25/14 at 11:05am, Dietary staff #F stated	S3299		

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S3299	Continued From page 11 yes, that's how we thaw them (pork chops). When asked if a policy and procedure manual available to review, Dietary staff #F stated none here that I know of... I worked in another facility nine years so I am aware of how to wash hands and so on... On 9/29/14 at 4:30pm, Facility Licensed Nurse #E provided facility policy and procedure titled Thawing Potentially Hazardous Foods. By review, this facility policy and procedure directed thawing of frozen food (meat) in a manner that included refrigeration, placing in cold agitated water, placing under cold running water, or placing in a microwave oven if using immediately. The Operator failed to ensure dietary staff stored all food under safe and sanitary conditions, and thawed frozen potentially hazardous food in accordance with facility policy and procedure.	S3299		