STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N058007	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF MARYSVILLE	1149 COUNTRY PLACE DRIVE MARYSVILLE, KS 66508

(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 represent the findings of the licensure resurvey for the above named facility conducted on 08/09/23 and 08/10/23.	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: K.A.R 26-41-204(i) The facility reported a census of 15 residents. The sample included 3 "Residents'" ((R's) 1, 2 and 3). Based on observation, interview, and record review the Operator failed to ensure qualified staff provided health care services in accordance with acceptable standards of practice for R's 1 and 2. Qualified staff failed to complete an assessment for R1 and R2 to ensure the bed assist devices were not a restraint, an assessment to determine the purpose of the devices and the R1 and R2's ability to safely use the devices, an assessment of the bed assist devices using the recommendations in the "Food and Drug Administration"(FDA) guidance for health care facilities and manufacturer and the Clinical Guidance for the Assessment and Implementation of Bed rails in Hospitals, Long Term Care Facilities, and Home Care setting to ensure that the devices were securely attached	S3171		

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

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S3171	Continued From page 1	S3171		

to the bed or bed frame and posed no risk for entrapment, and documented the finding in R1 and R2's resident record. The operator further failed to ensure qualified staff documented R1 and R2's functional ability based on the use of the assistive device and ensure it was listed on the resident "Functional Capacity Screen" (FCS) in the comments section, list a description of the device and its purpose in R1 and R2's "Negotiated Service Agreement" (NSA), and document periodic reassessments of R1 and R2's bed assist devices and their ability to safely use the devices in their resident record.

Findings included:

- Record review on 08/09/23 of the facility provided "Resident Roster" revealed two residents out of fifteen had "bed assist devices".

Record review for R1 revealed an admission date of 10/13/22 with diagnoses of essential (primary) hypertension and osteoarthritis.

Record review of R1 FCS dated 07/10/23 identified R1 required physical assistance with bathing, dressing, and transferring, she required supervision with toileting and walking, and she was independent with eating. She lacked the ability to manage her own medications and was occasionally incontinent of bladder. She had impaired short term memory, impaired long-term memory, impaired memory recall and impaired decision making. She was able to make herself understood and she understood others. She was marked with falls, impaired vision, impaired hearing, and used a walker mobility device.

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S3171	Continued From page 2 The FCS lacked documentation of a bed assist device in the comments section. Record review of R1 combined NSA and "Health Service Plan" (HSP) identified/instructed the facility staff would provide the following health services: physical assistance with bathing for safety reasons, and physical assistance with dressing. The document was amended on 1/12/23 to identify the resident took herself to the bathroom, and due to poor vision and weakness required assistance "to move around" and required staff assistance to meals and activities. The NSA/HSP lacked the description of a bed assist device and further lacked an assessment of R1 ability to safely use the bed assist device. Observation on 08/09/23 at 04:45PM of R1's bed revealed a U-shaped rail on the left side of the bed that was slid under the mattress. The device measured 12.5 inches in width and 34 inches in length, and had small, attached bars in the open space of the U shape for safety. There was a space of approximately a quarter of an inch where the legs of the device did not reach the floor. The device freely slid from under the mattress and was not securely attached to the bed. Interview on 08/09/23 at 05:36 PM with Operator B and "Director of Nursing" (DON) C, they confirmed R1 bed assist device was not securely attached to the bed, and further confirmed R1 resident record lacked an assessment to determine the purpose of the bed assist device, an assessment of R1 ability to safely use the bed	S3171		

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S3171	Continued From page 3 assist device, an assessment to ensure the bed assist device did not pose risk for entrapment of R1, and an assessment to ensure the device was securely attached to R1 bed. - Record review for R2 revealed an admission date of 12/02/19 with diagnoses of Diabetes Mellitus Type 2, coronary artery disease, congestive heart failure and hypertension. Review of R2 FCS identified R2 required physical assistance with bathing, and supervision with dressing. She lacked the ability to manage her own medications and was occasionally incontinent of bladder. She had impaired short term memory, impaired memory recall and impaired decision making. she was able to make herself understood and she understood others. She had impaired vision and impaired hearing. She used a walker and wheelchair mobility devices. The FCS lacked documentation of a bed assist device in the comments section. Review of R2 combined NSA/HSP identified/instructed the facility staff would provide the following health services: Physically assist with bathing for safety reasons, assist in choosing appropriate clothing, administer her medications, and dial the insulin pen. Resident self-injects her insulin. The NSA/HSP lacked the description of a bed assist device and further lacked an assessment of R1 ability to safely use the bed assist device.	S3171		

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S3171	Continued From page 4 Observation on 08/09/23 at 02:50 PM of R2 bed revealed the resident had bilateral rectangular half side rails on the bed with safety bars in the rectangular spaces for safety. The bars measured 32.5 inches in with and 22.5 inches in length. They were in the down position and covered by the bed spread. Attached to the top of the headboard of the bed with a large screw type clamp was a trapeze attachment. Interview on 08/09/23 at 02:50 PM with R2, she stated she "doesn't use" the side rails or the trapeze attachment. Interview on 08/09/23 at 05:36 PM with Operator A and DON B, they stated they did not know that R2 had bilateral half rails on her bed, but they were aware the trapeze was in place. They further confirmed that the resident record lacked an assessment to determine the purpose of the bed assist device, an assessment of R2 ability to safely use the bed assist device, an assessment to ensure the bed assist device did not pose risk for entrapment of R2, and an assessment to ensure the device was securely attached to R2 bed. The Operator failed to ensure qualified staff provided health care services in accordance with acceptable standards of practice for R's 1 and 2. Qualified staff failed to complete an assessment for R1 and R2 to ensure the bed assist devices were not a restraint, an assessment to determine the purpose of the devices and the R1 and R2's ability to safely use the devices, an assessment of the bed assist devices using the recommendations in the "Food and Drug Administration"(FDA) guidance for health care	S3171		

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S3171	Continued From page 5 facilities and manufacturer and the Clinical Guidance for the Assessment and Implementation of Bed rails in Hospitals, Long Term Care Facilities, and Home Care setting to ensure that the devices were securely attached to the bed or bed frame and posed no risk for entrapment, and documented the finding in R1 and R2's resident record. The operator further failed to ensure qualified staff documented R1 and R2's functional ability based on the use of the assistive device and ensure it was listed on the resident "Functional Capacity Screen" (FCS) in the comments section, list a description of the device and its purpose in R1 and R2's "Negotiated Service Agreement" (NSA), and document periodic reassessments of R1 and R2's bed assist devices and their ability to safely use the devices in their resident record.	S3171		
S3310 SS=D	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105	S3310		

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S3310	Continued From page 6 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207(c) The facility reported a census of 15 residents. The sample included 3 residents and 5 newly hired employees. Based on record review and interview the operator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for dietary staff A. Findings included: - Record review on 08/09/23 for newly hired dietary staff A revealed she began employment on 04/23/23, her employment record lacked the required documentation of the two step TB test being performed within seven days of hire. Interview on 08/10/23 at 09:55AM with Operator B, she confirmed staff A's employment record lacked the required documentation of the two step TB test being performed within seven days of hire. The operator failed to ensure the facility's compliance with the department's "Tuberculosis" (TB) guidelines for dietary staff A.	S3310		