STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N001006	A. BUILDING: _____ B. WING _____	11/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSTONE RESIDENTIAL CARE	2620 N KENTUCKY STREET IOLA, KS 66749

(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 a resurvey at the above named residential health care facility conducted on 11-14-18, 11-15-18, and 11-19-18.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 1 (#257) of 3 sampled residents, the operator failed to ensure designated facility staff shall conduct a screening to determine each resident's functional capacity following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for Resident #257 revealed admission on 7-23-18 with diagnoses Type 2 Diabetes Mellitus, Hypertension, Arthritis.	S3081		

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

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S3081	Continued From page 1	S3081		

The Functional Capacity Screen dated 7-23-18 recorded the resident to require supervision with bathing; independent with dressing, toileting, transfers, walking/mobility, eating and management of medications/treatments. Usually continent of bladder. Problems with short term memory. No problems with communication.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-23-18 recorded services for standby assistance with showers for safety. Mobility: report gait changes to nurse immediately. Fall Risk: no falls within last 3 years. Updated "10-25-18 every two hour toileting schedule" after a fall on 10-25-18.

The FCS lacked documentation of reassessment following a change in condition regarding toileting assistance, medication management and failed to identify falls/unsteadiness as a current problem/risk after the resident experienced falls on 8-11-18, and 10-25-18.

Unable to observe resident as he/she is currently out of facility receiving rehabilitation following a hip fracture on 11-4-18.

Nurse's Notes:
8-11-18 at 5:35 pm: "Notified by staff that resident had fallen in room and received golf ball size hematoma to the back of head. Family notified...left via ambulance to hospital to be evaluated..." Signed by Licensed Staff B.
8-15-18 (unknown time): "Resident self medicates with over the counter medications. However, staff will administer Lisinopril and monitor blood pressures. Resident and (family member) in verbal agreement." Signed by Licensed Staff B.
10-25-18 at 1:05 am: "Resident was hollering out.

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S3081	Continued From page 2 Certified Nurse Aide investigated and observed resident on floor beside bed...Put personal body alarm back on resident. He/She had taken it off before getting up..." Signed by Certified Staff C. Interviews on 11-14-18 at 3:26 pm and 3:50 pm with Licensed Staff B and Operator confirmed the resident experienced a significant change following move from home into the facility. Stated resident was only taking some over the counter medications upon admission and when medical care provider added prescription medications (for increasing agitation and symptoms of an eye infection), the facility staff administered and stored all prescription medications. Confirmed resident was a noted fall risk after fall on 8-11-18 and in October, was placed on hourly checks due to increased agitation and fall risk. For Resident #257, the operator failed to ensure designated facility staff conducted a screening to determine each resident's functional capacity following any significant change in condition as defined in K.A.R. 26-39-100 when the facility began managing some of the resident's medications and the resident experienced two falls with the addition of toileting assistance.	S3081		
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:	S3171		

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S3171	Continued From page 3 KAR 26-41-204(i) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 1 (#257) of 3 sampled residents, the operator failed to ensure all health care services shall be provided to the resident by qualified staff in accordance with acceptable standards of practice when the licensed nurse delegated to certified staff a function that required professional nursing judgment. Findings included: - Record review for Resident #257 revealed admission on 7-23-18 with diagnoses Type 2 Diabetes Mellitus, Hypertension, Arthritis. The Functional Capacity Screen dated 7-23-18 recorded the resident to require supervision with bathing; independent with dressing, toileting, transfers, walking/mobility, eating and management of medications/treatments. Usually continent of bladder. Problems with short term memory. No problems with communication. (Note: The FCS failed to accurately reflect the resident's status regarding risk for falls and medications management.) The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-23-18 recorded services for standby assistance with showers for safety. Mobility: report gait changes to nurse immediately. Fall Risk: no falls within last 3 years. Updated 10-25-18 with every two hour toileting schedule (after a fall on 10-25-18). Nurse's Notes: 8-11-18 at 5:35 pm: "Notified by staff that resident	S3171		

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S3171	Continued From page 4	S3171		

had fallen in his/her room and received golf ball size hematoma to the back of head. Family notified. This nurse notified hospital and gave report to emergency room. Resident left via ambulance to hospital to be evaluated. 7:45 pm This nurse returned with resident from hospital with new orders to complete neuro checks every 2 hours times 2, then if stable every 4 hours times 2 and discontinue if stable. Manual blood pressure 4 times a day. Provided and educated staff with neurological flow sheet to complete as ordered. Instructed staff to provide ice to back of head to decrease pain and swelling, on 10 minutes off 20 minutes times 2 hours if needed. Will continue to monitor. Family notified." Signed by Administrative Nurse B.

Neurological Flow Sheet documented neurological checks performed as follows:
8-11-18 at 9:00 pm by Licensed Staff B.
8-11-18 at 10:00 pm and 12:00 am by Certified Staff C
8-12-18 at 4:00 am by Certified Staff D
8-12-18 at 8:00 am by Certified staff E

Printed instructions for staff:
8-11-18 "(Resident #257) fell tonight and received a closed head injury. He/She has a golf ball size hematoma to the back of head. He/She was evaluated at (hospital). We need to complete neuro checks. See attached form.
Neuro checks included: Level of consciousness: alert and oriented times 3 = resident knows name, where he/she is, and knows either the date or time and follows commands. Or is he/she confused or lethargic? Movement: Can he/she wiggle toes and lift each leg? are movements smooth, jerky or does he/she have a tremor? Hand grasps: Have resident squeeze each of your pointer finger at the same time; are hand

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S3171	Continued From page 5	S3171		

strengths weak or strong and are they equal or is one side stronger than the other? Pupil check: perform a pupil check: Shine the pen light in the eye briefly then look for: are the pupil round and what size are they (you can measure them with the side of the pen light, it has circles with number below to match with), do the pupils react to the light briskly or slowly (do they get smaller or bigger)? Speech: is speech clear and understandable or slurring? Neuro checks every two hours times 2: 10:00 pm and 12:00 am. Then every four hours times two: 4:00 am, 8:00 am. May discontinue after this if he/she is stable. Manual blood pressures four times an day until Tuesday morning: 10:00 pm, 4:00 am, 10:00 am, 4:00 pm." Signed by Licensed Staff B.

The sheet was initialed as reviewed by Licensed Nurse B and documented "Neuro checks completed 8-13-18" Only blood pressures 4 times a day now.

Interview on 11-14-18 at 3:30 pm with Licensed Nurse B reviewed staff initials on neuro check flow sheet and confirmed certified staff completed the neuro checks as documented above. Confirmed he/she provided the written instructions for staff to follow. Confirmed he/she delegated the nursing procedure that required professional nursing judgement to certified medication aides and a certified nurse aide.

For Resident #257, the operator failed to ensure all health care services shall be provided to the resident by qualified staff in accordance with acceptable standards of practice when the licensed nurse delegated to certified staff a function that required professional nursing judgment.

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S3228	Continued From page 6	S3228		
S3228 SS=E	26-41-205 (l) (3) Medication Regimen Review Record (l) (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(l)(3) The facility reported a census of 26 residents. The sample included 3 residents. Based on record review and interview for 2 (#135, #257) of 3 sampled residents, the operator failed to ensure that the medication regimen review is kept in each resident's clinical record. Findings included: - Record review for Resident #135 revealed admission on 11-1-3-15 with diagnoses Coronary Artery Disease, Dyslipidemia, Hypothyroidism, Type 2 Diabetes Mellitus, Congestive Heart Failure, Hypertension, and Peptic Ulcer Disease. The Functional Capacity Screen dated 3-28-18 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 3-28-18 recorded under Medication Management: Staff will provide physician ordered medications. Resident will self administer insulin.	S3228		

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S3228	Continued From page 7 The record lacked documentation of a quarterly medication regimen review. - Record review for Resident #257 revealed admission on 7-23-18 with diagnoses Type 2 Diabetes Mellitus, Hypertension, Arthritis. The Functional Capacity Screen dated 7-23-18 recorded the resident to be independent with management of medications/treatments. (Note: The FCS failed to accurately reflect the resident's status regarding medication management.) The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-23-18 recorded Resident will self administer and store all medications. (Note: the NSA/HCSP failed to document the change when facility staff began administering prescribed medications.) The record lacked documentation of a quarterly medication regimen review. On 11-15-18 at 11:15 am Licensed Staff B provided copies of quarterly medication regimen review reports dated 6-5-17, 12-17-17, 2-23-18, 6-25-18 and 9-21-18. Stated he/she keeps all the documentation in a notebook labeled Pharmacy Review. Confirmed the pharmacist did not document in the record that the reviews had been completed and the records lacked documentation of quarterly medication regimen reviews. Facility policy/procedure for "Medication Regimen Review" stated: "3. Written documentation of the review will be provided to the facility from the licensed pharmacist. The documentation of the review will be maintained in each resident's clinical record." The facility failed to follow its	S3228		

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S3228	Continued From page 8 policy. For Residents #135, #257, the operator failed to ensure that the medication regimen review is kept in each resident's clinical record.	S3228		