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	175347	A. BUILDING _____ B. WING _____	C 03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CHEYENNE COUNTY	820 S DENISON STREET ST FRANCIS, KS 67756

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #138900.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 3 residents, which were	F 609		

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

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reviewed for accidents. Based on record review, interview, and observation, the facility failed to report to the state agency, in a timely manner, an incident regarding 1 of 3 sampled residents. Staff transferred Resident #1 from his/her wheelchair into his/her bed and he/she obtained a laceration that required emergency room care and 30 sutures to repair.

Findings included:

- Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 12/18/18, documented the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition, with no behaviors. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfer, toilet use, extensive assistance of 1 staff for locomotion on and off the unit, dressing, personal hygiene, bathing, limited assistance of 1 staff for ambulating in his/her room and the corridor, ate independently after staff set up his/her meal. The MDS documented the resident's balance was not steady, could only stabilize with staff assistance, and used a walker and wheelchair for mobility.

The (ADL) activity of daily living (CAA) Care Area Assessment, dated 8/17/18, documented the resident was recently in the hospital for pneumonia and was very weak, which made it hard for him/her to help much with his/her ADLs.

The 12/26/18 care plan directed staff to assist the resident with repositioning in bed, transfer between surfaces with 1 staff with use of walker and gait belt, and a 1/4 inch rail on his/her bed to use to assist with transfers, get up and down, out of bed, and reposition himself/herself in bed. The

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care plan lacked documentation of the resident's laceration on 2/9/19 and direction to staff for care of the resident's laceration.

The 2/9/19 at 2:45 AM, nurse's note documented the resident transported by ambulance to the emergency room for a laceration on his/her left lower leg at 8:45 PM.

The 2/10/19 at 2:00 AM, nurse's note documented staff contacted the hospital for more information regarding the resident's laceration. The note documented the resident received 30 sutures that would be removed in 10 days.

On 3/6/19 at 11:40 AM, observation of the resident's bed revealed a 1/4 positioning bed rail with no sharp or rough edges.

On 3/6/19 at 2:00 PM, observation revealed the resident sat at a table in the common gathering area with a plate of food in front of him/her. Further observation revealed an intact dressing on his/her lower left leg with no signs of drainage on the dressing.

On 3/7/19 at 11:25 AM, observation revealed the resident sat in his/her wheelchair in his/her room and Licensed Nurse G prepared to change the dressing on the resident's lower left leg. Licensed Nurse G washed his/her hands, applied gloves, removed the old dressing, then cleaned the wound with sterile saline before applying the treatment ordered by the physician. Observation revealed the sutures were intact, black eschar (dead tissue) noted in the middle of the wound, and slight redness around the sutures, with some bleeding.

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On 3/7/19 at 10:35 AM, Administrative Staff A stated he/she was unaware of the incident until approximately 2 weeks after it occurred, and he/she started the investigation at that time. Administrative Staff A stated none of the staff reported the incident, and he/she thought the director of nursing at that time investigated and reported the incident to the state. Administrative Staff A stated there was a definite break down in their system.

On 3/7/19 at 10:50 AM, Administrative Staff B stated he/she was unaware of the incident until he/she received an email from the resident's representative on 2/20/19 (10 days after the incident). Administrative Staff B stated he/she did not know it had not been reported or investigated prior to that date. Administrative Staff B stated the incident should have been reported immediately.

On 3/7/19 at 1:00 PM, Administrative Nurse C stated he/she was unaware of the incident on 3/1/19, and reported it to the state agency on 3/5/19 (24 days after the incident occurred). Administrative Nurse C stated the incident should have been reported and investigated sooner.

The facility's July 2017 Abuse, Neglect and Exploitation policy for investigation and reporting documented all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin will be reported by the facility administrator or his/her designee, to the state licensing/certification agency responsible for surveying/licensing the facility. The policy documented an alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source, would be reported immediately, but not

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F 609	Continued From page 4 later than 2 hours if the alleged violation resulted in serious bodily injury, or 24 hours if the alleged violation does not involve abuse, and has not resulted in serious bodily injury. The policy documented the administrator or his/her designee would provide the appropriate agencies with a written report of the findings of the investigation within 5 working days of the occurrence of the incident. The facility failed to report to the state agency and investigate an incident that occurred on 2/9/19, until 3/5/19, after Resident #1 sustained a laceration to his/her lower left leg during a transfer, that required emergency treatment.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		

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F 657	Continued From page 5 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 3 residents. Based on observation, record review, and interview, the facility failed to update and revise care plans for 3 of 3 sampled residents after accidents and falls. (#1, #2, #3) Findings included: - Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 12/18/18, documented the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition, with no behaviors. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfer, toilet use, extensive assistance of 1 staff for locomotion on and off the unit, dressing, personal hygiene, bathing, limited assistance of 1 staff for ambulating in his/her room and the corridor, ate independently after staff set up his/her meal. The MDS documented the resident's balance was not steady, could only stabilize with staff assistance, and used a walker and wheelchair for mobility. The (ADL) activity of daily living (CAA) Care Area Assessment, dated 8/17/18, documented the resident was recently in the hospital for pneumonia and was very weak, which made it hard for him/her to help much with his/her ADLs.	F 657		

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The 12/26/18 care plan directed staff to assist the resident with repositioning in bed, transfer between surfaces with 1 staff with use of walker and gait belt, and a 1/4 positioning bed rail on his/her bed to use to assist with transfers, get up and down, out of bed, and reposition himself/herself in bed. The care plan lacked documentation of the resident's laceration on 2/9/19, direction to staff for care of the resident's laceration, and interventions to prevent future injury.

The 2/9/19 at 2:45 AM, nurse's note documented the resident transported by ambulance to the emergency room for a laceration on his/her left lower leg at 8:45 PM.

The 2/10/19 at 2:00 AM, nurse's note documented staff contacted the hospital for more information regarding the resident's laceration. The note documented the resident received 30 sutures that would be removed in 10 days.

On 3/6/19 at 11:40 AM, observation of the resident's bed revealed a 1/4 positioning bed rail with no sharp or rough edges.

On 3/6/19 at 2:00 PM, observation revealed the resident sat at a table in the common gathering area with a plate of food in front of him/her. Further observation revealed an intact dressing on his/her lower left leg with no signs of drainage on the dressing.

On 3/6/19 at 1:15 PM, Licensed Nurse H stated staff had not updated the care plan after the resident acquired a laceration to his/her left lower leg on 2/19/19, with direction to staff for care of

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the laceration and interventions to prevent further injury.

On 3/7/19 at 1:00 PM, Administrative Nurse C verified staff had not updated the care plan after the resident sustained a large laceration to his/her left lower leg on 2/9/19, and the care plan lacked information for staff to know how to care for the resident.

The facility's 12/2016 policy for Care Plans documented the assessments of residents are on-going and care plans are revised as information about the residents and the resident's condition changes. The interdisciplinary Team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment.

The facility failed to review and update Resident #1's care plan after he/she acquired a laceration and required wound treatment and interventions to prevent further injury. This placed the resident at risk for further wound damage, infection, and accidents.

- Resident #2's annual (MDS) Minimum Data Set assessment, dated 1/2/19 documented the resident had a (BIMS) Brief Interview for Mental Status score of 13, which indicated intact cognition, and displayed rejection of care 1 to 3 days of the look back period. The MDS documented the resident required limited assistance of 1 staff for transfers, locomotion on and off the unit, dressing, personal hygiene,

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supervision of 1 staff for bed mobility, extensive assistance of 1 staff for bathing, and required supervision of 1 staff after set up for eating. The MDS documented the resident used no mobility device and had 1 fall with minor injury since his/her prior assessment.

The annual (CAA) Care Area Assessment for (ADLs) Activities of Daily Living, dated 1/2/19, documented the resident had poor memory and decision making but continued to desire independence and would not call for staff assistance.

The 1/16/19 care plan documented the resident at risk for falls due to gait and balance problems. The care plan documented staff would educate the resident about safety reminders, what to do if a fall occurred, and be sure the resident wore appropriate footwear with rubber soles when he/she ambulated. The care plan lacked documentation of the resident's fall on 1/22/19 and further interventions to prevent future falls.

The 1/22/19 at 1:10 AM (late entry), nurse's note documented staff found the resident on the floor, when he/she ambulated to the bathroom without assistance, fell, hit his/her head on the wall, and landed on the floor. The note documented the resident had skin tears to his/her right elbow, forearm, and wrist, as well as a 3 (cm) centimeter raised area of his/her left parietal bone (a bone forming the central side and upper back part of each side of the skull).

On 3/6/19 at 2:30 PM, observation revealed the resident sat in a chair in his/her room, with oxygen by nasal cannula (nose piece) in place, and his/her walker within reach.

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On 3/6/19 at 1:15 PM, Licensed Nurse H stated staff had not updated the care plan after the resident had a fall with minor injuries on 1/22/19.

On 3/7/19 at 1:00 PM, Administrative Nurse C verified staff had not updated the care plan after the resident had a fall with skin tears and a bump on his/her head on 1/22/19. Administrative Nurse C verified the care plan lacked new interventions to help reduce or prevent future falls.

The facility's 12/2016 policy for Care Plans documented the assessments of residents are on-going and care plans are revised as information about the residents and the resident's condition changes. The interdisciplinary Team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment.

The facility failed to review and revise Resident #2's care plan after he/she fell and suffered minor injuries on 1/22/19, placing the resident at risk for further falls and injury.

- Resident #3's admission (MDS) Minimum Data Set assessment, dated 2/12/19, documented the resident had a (BIMS) Brief Interview for Mental Status score of 10, which indicated moderately impaired cognition, physical behaviors directed toward others, rejected care 1 to 3 days of the look back period, and wandered 4-6 days of the look back period. The MDS documented the resident required limited assistance of 1 staff for

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bed mobility, transfers, walking in the corridor, locomotion off the unit, dressing, toilet use, extensive staff assistance of 1 for personal hygiene, supervision of 1 staff for locomotion off the unit, and supervision after staff set up for eating. The MDS documented the resident had no upper or lower extremity impairment and used a walker for mobility.

The 2/12/19 (CAA) Care Area Assessment for (ADLs) Activities of Daily Living documented the resident had confusion, poor judgement, and refused and resisted assistance from staff.

The 2/22/19 care plan documented the resident ambulated independently with his/her walker and needed supervision while he/she got used to the facility. The care plan directed staff to place the resident's call light in reach with a prompt response to his/her request for assistance. The care plan lacked documentation of the resident's fall on 2/11/19 which resulted in a fracture of his/her left arm, and interventions to help reduce or prevent falls.

The 2/11/19 at 8:55 PM, nurse's note documented the resident ambulated out of his/her room and reported to the nurse that he/she had fallen in his/her room, and complained of pain in his/her left wrist. The note documented the resident reported he/she got out of the chair and was undressing for bed when he/she fell.

The 2/11/19 at 3:30 PM, nurse's note documented the physician's office requested the resident come to discuss the x-ray results which documented fractures (broken bones) of the left radial and left ulna (bones going from the wrist to the elbow).

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F 657	Continued From page 11 On 3/6/19 at 3:30 PM, observation revealed the resident ambulated in the hall with his/her walker, with an arm rest on the left side of the walker and a cast in place on his/her left forearm. On 3/6/19 at 1:15 PM, Licensed Nurse H stated staff had not updated the care plan after the resident had a fall with a fracture to his/her left arm on 2/11/19, with interventions to prevent further falls. On 3/7/19 at 1:00 PM, Administrative Nurse C verified staff had not updated the care plan after the resident sustained a fractured left arm when he/she fell on 2/11/19, and the care plan lacked new interventions to prevent further falls. The facility's 12/2016 policy for Care Plans documented the assessments of residents are on-going and care plans are revised as information about the residents and the resident's condition changes. The interdisciplinary Team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment. The facility failed to review and revise Resident #3's care plan after he/she fell on 2/11/19 and sustained a fracture of his/her left arm, placing the resident at risk for further falls and injury.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 12 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 28 residents. The sample included 3 residents, which were reviewed for quality of care. Based on record review, interview, and observation, the facility failed to provide wound care as ordered by the physician, for 1 of 3 sampled residents. (#1) Findings included: - Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 12/18/18, documented the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition, with no behaviors. The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfer, toilet use, extensive assistance of 1 staff for locomotion on and off the unit, dressing, personal hygiene, bathing, limited assistance of 1 staff for ambulating in his/her room and the corridor, ate independently after staff set up his/her meal. The MDS documented the resident's balance was not steady, could only stabilize with staff assistance, and used a walker and wheelchair for mobility. The (ADL) activity of daily living (CAA) Care Area Assessment, dated 8/17/18, documented the resident was recently in the hospital for	F 684		

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(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) COMPLETION DATE
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pneumonia and was very weak, which made it hard for him/her to help much with his/her ADLs.

The 12/26/18 care plan directed staff to assist the resident with repositioning in bed, transfer between surfaces with 1 staff with use of walker and gait belt, and a 1/4 inch rail on his/her bed to use to assist with transfers, get up and down, out of bed, and reposition himself/herself in bed. The care plan lacked documentation of the resident's laceration on 2/9/19 and direction to staff for care of the resident's laceration.

The 2/9/19 at 2:45 AM, nurse's note documented the resident transported by ambulance to the emergency room for a laceration on his/her left lower leg at 8:45 PM.

The 2/10/19 at 2:00 AM, nurse's note documented staff contacted the hospital for more information regarding the resident's laceration. The note documented the resident received 30 sutures that would be removed in 10 days.

The 2/21/19 at 10:48 AM, physician's note documented the resident was seen in the emergency room 10 days ago when he/she suffered a laceration to his/her left lower leg, and 30 sutures were placed. The note documented the laceration measured 12 (cm) centimeters, crescent shaped, with simple, interrupted and running sutures in place. The note documented there was minimal erythema (redness or inflammation of the skin) around some portions of the wound that appeared to be from irritation. The note documented there were no signs or symptoms of infection, open areas or drainage.

The 2/21/19 physician's order directed staff to

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	175347	A. BUILDING _____ B. WING _____	C 03/07/2019

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provide wound care every 48 hours and to not leave the dressing on any longer to prevent it from drying out and further wound damage. The physician's order documented staff should apply Aquacel AG Extra [a dressing composed of two layers of Hydrofiber technology that are stitched together. It is specifically suited to help manage moderate to highly exuding (fluid that leaks out of body vessels and tissues) wounds], moistened with sterile saline over the black eschar only, cover with an absorbent foam and Mepilex border (an all-in-one foam dressing that maintains a moist wound environment and seals the wound edges to prevent leaking onto surrounding skin). The order documented the physician would see the resident for follow-up on 2/26/19.

The 2/26/19 at 9:13 AM, physician's note documented the resident was seen for follow-up of his/her left lower leg wound. The note documented the wound and the Aquacel AG Extra was very dried out, with an area of black eschar centrally, approximately 30% of the wound surface, dense and not soft. The note documented the physician changed the dressing changes to every 24 hours due to the dryness. The note documented after the physician reviewed the treatment orders with Licensed Nurse H, the dressing had not been changed since 2/21/19, and he/she would not change to daily dressing changes, but leave them at every 48 hours.

The 2/26/19 physician's order directed staff to continue the same treatment as 2/21/19 and the physician would see the resident for follow-up on 3/4/19.

A review of the resident's February 2019 (TAR)

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Treatment Administration Record lacked documentation staff changed the resident's dressing every 48 hours as ordered by the physician. The TAR documented the dressing had not been changed from 2/21/19 to 2/26/19 (5 days).

The 3/4/19 at 9:01 AM, physician's note documented the resident's wound had minimal erythema, no signs or symptoms of infection or drainage. The note documented the wound was very dried out, with an area of black eschar centrally, approximately 30% of the wound surface, hard and dried out. The physician ordered the dressing changes increased to daily to prevent drying out and further wound bed damage.

The 3/4/19 physician's order directed staff to increase the dressing changes to daily and the physician would see the resident for follow-up on 3/14/19.

A review of the resident's March 2019 TAR lacked documentation staff changed the resident's dressing on the every 48 hours as ordered by the physician. The TAR documented the dressing had not been changed from 3/1/19 to 3/5/19 (5 days). The physician's order changed on 3/4/19 from every 48 hours to daily and lacked documentation of the dressing changed on the 5th.

On 3/6/19 at 11:40 AM, observation of the resident's bed revealed a 1/4 positioning bed rail with no sharp or rough edges.

On 3/6/19 at 2:00 PM, observation revealed the resident sat at a table in the common gathering

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area with a plate of food in front of him/her. Further observation revealed an intact dressing on his/her lower left leg with no signs of drainage on the dressing.

On 3/7/19 at 11:25 AM, observation revealed the resident sat in his/her wheelchair in his/her room and Licensed Nurse G prepared to change the dressing on the resident's lower left leg. Licensed Nurse G washed his/her hands, applied gloves, removed the old dressing, then cleaned the wound with sterile saline before applying the treatment ordered by the physician. Observation revealed the sutures were intact, black eschar (dead tissue) noted in the middle of the wound, and redness around the sutures, with some bleeding.

On 3/6/19 at 1:15 PM, Licensed Nurse H verified the physician ordered dressing changes to the resident's left lower leg every 48 hours and no documentation staff changed the dressing from 2/21/19 to 2/26/19.

On 3/7/19 at 1:00 PM, Administrative Nurse C verified the resident's TAR lacked documentation staff changed the resident's dressing according to the physician's order in February and March.

The facility failed to provide treatment and care as ordered by the physician for Resident #1's dressing changes, which placed the resident at risk for infection and further skin damage.