STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 a Health Resurvey.	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 9 residents. Based on observation, record review and interview the facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary and comfortable interior, on 1 of 2 halls, for Resident #25 and the 24 residents, who reside on the south hall. Findings included: - Resident #25's quarterly (MDS) Minimum Data Set assessment, dated 02/28/17, recorded the resident had a (BIMS) Brief interview for Mental Status score of 5 (severe cognitive impairment). The MDS also recorded the resident required extensive staff assistance with dressing, toileting and personal hygiene, and used a walker for mobility. The MDS further recorded the resident received a diuretic (medication to promote the formation and excretion of urine) everyday, and was occasionally incontinent of urine. The 08/25/16 admission (CAA) Care Area Assessment for urinary incontinence recorded the resident had a diagnosis of (BPH) Benign Prostatic Hyperplasia (non cancerous	F 253		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 253	Continued From page 1	F 253		

enlargement of the prostate which can lead to urinary frequency) and used a diuretic medication everyday. The CAA also recorded the resident often had trouble finding his/her bathroom due to dementia (progressive mental disorder characterized by failing memory and increased confusion).

The 03/08/17 care plan recorded the resident was incontinent of urine and wore incontinent pull-ups. The care plan directed staff to toilet the resident every 2 hours, upon request, or when the resident was anxious and restless.

The facility's Toileting Program Assessment, dated 01/22/17, recorded the resident often urinated on the floor and/or in the trash can in his/her room.

On 05/16/17 at 10:37 AM, observation revealed the resident seated in a cloth recliner in his/her room. Continued observation revealed the carpeted room had a very strong urine odor permeating throughout the entire room, and a dehumidifier (device to remove moisture from the air) and automatic air freshener in the room.

On 05/16/17 at 11:02 AM, observation revealed the window near the exit door at the south end of the hall was open and allowed a breeze of fresh air to enter the building. Continued observation revealed Resident #25's room door was open and a urine odor lingered into the hallway.

On 05/17/17 at 7:48 AM, observation revealed Resident #25's room door open and a urine odor permeated the hall and multiple resident rooms.

On 05/17/17 at 7:55 AM, Housekeeping Staff G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 253	Continued From page 2	F 253		

stated the urine odor in the resident's room had been present for many months and housekeeping staff cleaned the carpet in the resident's room every 2 weeks.

On 05/17/17 at 9:29 AM, Nurse Aide H stated the confused resident was on a toileting schedule, but often urinated on the carpeted floor in his/her room. Nurse Aide H also stated the resident's room had a urine odor for many months.

On 05/17/17 at 10:02 AM, Nurse J stated the resident had a history of urinating on the carpeted floor in his/her room and the room had a strong urine odor, that often permeated throughout the hall and into other resident's rooms.

On 05/18/17 at 8:22 AM, Administrative Nurse B stated the resident had a history of urinating on the carpeted floor in his/her room and the urine odor in the resident's room created an uncomfortable environment for the resident to reside. Administrative Nurse B also stated the urine odor often permeated the hall and could be offensive to other residents and visitors.

The facility's Housekeeping Policy, dated 03/2016, directed staff to implement cleaning procedures to maintain a clean/organized environment and provide a sanitary, infection free living space for the residents, who reside in the facility.

The facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary and comfortable interior for Resident #25 and the 24 residents, who reside on the south hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 323	Continued From page 3	F 323		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 9 residents. Based on observation and interview the facility failed to provide an environment free from accident hazards for the 29 residents who reside in the facility, including 1 cognitively impaired, independently mobile resident. Findings included:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 323	Continued From page 4	F 323		

- On 5/15/17 at 4:40 PM, during initial tour, observation in the activity room, revealed a paring knife (a small utility knife that can be used for peeling and chopping fruits and vegetables) in an unlocked top drawer, to the right of the sink, and a paring knife in an unlocked 3rd drawer, underneath the microwave.

On 5/15/17 at 4:53 PM, during initial tour, observation revealed a screwdriver in an unlocked cupboard, between the mechanical room and the restroom in the kitchenette.

On 5/15/17 at 4:45 PM, Activity Staff A verified the knives in the above areas, of the activity room, should not be there, and removed them from the drawers.

On 5/15/17 at 4:55 PM, Nurse Aide C verified the screwdriver in the kitchenette, stated it belonged to the kitchen, and he/she removed it.

On 5/18/17 at 10:15 AM, Administrative Nurse B stated he/she would expect staff to ensure knives and screwdrivers were under lock and key.

On 5/18/17 at 6:28 PM, Administrative Nurse B verified, by facsimile, the facility had 1 cognitively impaired, independently mobile resident.

Upon request, the facility failed to provide a policy regarding the storage of knives and screwdrivers.

The facility failed to provide an environment free from accident hazards for the 29 residents who reside in the facility, including 1 cognitively impaired, independently mobile resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 431	Continued From page 5	F 431		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 431	Continued From page 6	F 431		

(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 9 residents. Based on observation, record review, and interview the facility failed to ensure medications were not expired in 1 of 1 medication room.

Findings included:

- On 5/15/17 at 4:10 PM, during initial tour, observation of 1 of 1 medication room revealed the following:

1-30 pack vials of Albuterol nebulizer solution (medication that relaxes muscles in the airway and increases airflow to the lungs) with an expiration date of 3/14/17.
1-30 pack vials of DuoNeb nebulizer solution (combination solution that relaxes muscles in the airway and increases airflow to the lungs) with an expiration date of 3/14/17.

On 5/15/17 at 4:12 PM, observation of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 431	Continued From page 7	F 431		

facility's E-kit (Emergency medication kit) revealed 1-Glucagon (a hormone that raises the level of glucose (a type of sugar) in the blood) pen with an expiration date of March, 2017. 1-Enema (liquid treatment most commonly used to treat severe constipation) kit with an expiration date of 3/14/17.

On 5/15/17 at 4:13 PM, review of the Emergency medication kit inventory list revealed a lack of correctly documented list of medications, number of pills, or expirations dates of the medications in the E-kit.

On 5/15/17 at 4:28 PM, Nurse D verified the above items were expired and needed disposed of, and he/she reported this to the Director of Nursing.

On 5/16/17 at 2:00 PM, Administrative Nurse B stated the medications in the E-Kit were monitored by a different pharmacy, and when staff used a medication in the E-kit, staff were to notify the pharmacy and the medication was replaced.

On 5/18/17 at 8:40 AM, Administrative Nurse B stated the nurse or pharmacy should check the E-kit at least monthly for expired medications. Administrative Nurse B stated staff should check the regular medications (stock and prescription) at least monthly to make sure they were not expired.

The facility's Emergency Drug Box policy, dated September, 2012, stated a list of emergency medications including the amounts, and dosages/strengths would be posted on the outside of the box. The pharmacist was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175347	A. BUILDING _____ B. WING _____	05/22/2017

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 431	Continued From page 8 responsible for monitoring expiration dates. The facility failed to properly label and store medications in 1 of 1 medication room in the facility, placing the 29 residents in the facility at risk for receiving inappropriate or expired medications.	F 431		