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 _____	R-C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CHEYENNE COUNTY	820 S DENISON ST 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 Non-Compliance Revisit and Complaint #91506.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: The facility had a census of 30 residents. The	{F 157}		

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

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{F 157}	Continued From page 1 sample included 3 residents. Based on observation, record review and interview, the facility failed to notify the physician regarding a change in condition for 1 of the 3 residents, who had a change in condition with increased symptoms after being diagnosed with a (UTI) urinary tract infection, did not receive physician ordered antibiotics, and required admission to the hospital (#1) Findings included: - Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 9/22/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 11, which indicated he/she had moderate cognitive impairment. The MDS further indicated the resident had frequent urinary incontinence and required extensive assistance from the staff for transfers and toileting. The 9/11/15 care plan directed the staff to monitor and document any signs or symptoms of a(UTI), and report to the nurse. The care plan stated the resident was at risk for a UTI, and needed assistance of 1 staff and a walker to ambulate into and out of the bathroom. The 8/27/15 at 8:48 PM, nurse's note stated the staff contacted the physician regarding the resident's condition of a "glassy look" to his/her face, blood pressure of 161/78 (normal is 120/80) and a rapid pulse of 107 (normal is 60-100). There was no documentation of the resident's temperature. The staff received an order from the physician for a urinalysis with culture and sensitivity if indicated. The 8/28/15 at 9:14 AM, nurse's notes stated the resident needed much encouragement to drink	{F 157}		

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{F 157}	Continued From page 2 fluids, and staff had to frequently cue the resident to drink. The 9/2/15 at 8:12 AM, nurse's notes stated the physician ordered macrobid (an antibiotic used to treat UTI), 100 (mg) milligrams, 2 times a day, for 5 days. The 9/6/15 at 9:20 AM, nurse's notes stated the resident wanted to sleep all morning, and needed constant verbal cues to wake up, eat breakfast, and drink fluids. The note stated the resident would wake up, and go right back to sleep, and the night shift staff reported he/she slept all night, and then continued to sleep all day. The 9/8/15 at 6:10 AM, nurse's note stated the resident would not sit or stand up, and reported he/she did not feel well. At 2:29 PM, the note stated the resident had slept all morning, and continued to sleep at this time. The 9/8/15 at 2:00 PM, physician's note stated the resident was seen for an acute visit due to nursing staff concerns of increased sleep and decreased oral intake. The resident had been treated for a UTI with macrobid since 9/2/15, but had not received the 2 times a day dosing until 9/7/15. The physician ordered macrobid, 100 mg, 2 times a days for 5 more days, and directed the staff to draw a CBC (complete blood count), CMP (complete metabolic count), and a (TSH) thyroid-stimulating hormone blood test), for fever and fatigue. On 9/29/15 at 8:00 AM, observation revealed the staff propelled the resident in his/her wheelchair to the dining room for breakfast. The resident appeared alert, and he/she talked with the staff. Further observation revealed the staff served the	{F 157}		

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{F 157}	Continued From page 3 resident coffee, cranberry juice and water, and the resident was able to take sips of the drinks on his/her own, drinking all the coffee, juice, and most of the water. On 9/29/15 at 1:45 PM, Nurse A stated the resident appeared to sleep more than normal while he/she received an antibiotic for a UTI. On 9/29/15 at 2:10 PM, Nurse B stated the resident slept more, became weaker, and would not eat or drink very well during the time he/she received treatment for a UTI. On 9/29/15 at 4:00 PM, Administrative Nurse D stated the resident showed signs of increased sleepiness and decreased oral intake on 8/28/15 and the physician ordered an antibiotic for a UTI. Administrative Nurse D stated the resident continued to decline and staff had not notified the physician until 9/8/15, 6 days after the resident's change in condition. Administrative Nurse D stated he/she would have expected staff to notify the physician before 9/8/15. The facility failed to notify the physician of a change in Resident #1's condition, for 6 days after the resident demonstrated a physical decline in his/her condition related to a UTI.	{F 157}		
{F 309} SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		

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{F 309}	Continued From page 4 This Requirement is not met as evidenced by: The facility had a census of 30 residents. The sample included 3 residents. Based on observation, record review and interview, the facility failed to provide the necessary care and services for 1 of the 3 residents sampled, when the staff did not thoroughly assess a resident with increased symptoms of a (UTI) urinary tract infection, and required admission to the hospital. (#1) Findings included: - Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 9/22/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 11, which indicated he/she had moderate cognitive impairment. The MDS further indicated the resident had frequent urinary incontinence and required extensive assistance from the staff for transfers, toileting, and limited staff assistance for eating. The 9/11/15 care plan directed the staff to monitor and document any signs or symptoms of (UTI) urinary tract infection, and report to the nurse. The care plan stated the resident was at risk for UTI, and needed assistance of 1 staff and a walker to ambulate into and out of the bathroom. The 8/27/15 at 8:48 PM nurse's notes stated the staff contacted the physician regarding the resident's condition of "glassy look" to his/her face, blood pressure of 161/78 (normal is 120/80), and pulse of 107 and rapid (normal is a range of 60-100). The staff received an order from the physician for a urinalysis with culture and sensitivity if indicated. There was no documentation of the resident's temperature.	{F 309}		

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{F 309}	Continued From page 5 The urinalysis, dated 8/27/15, revealed the resident had a small amount of leukocytes (presence of infection), a trace of blood, and 11-15 white blood cells (normal is 0-5). The 8/27/15 urine culture revealed the infection was susceptible to the medication nitrofurantoin (generic name for macrobid). The 8/28/15 at 9:14 AM nurse's note stated the resident needed much encouragement to drink fluids, and staff had to frequently cue the resident to drink. The 9/2/15 at 8:12 AM nurse's note stated the physician ordered macrobid (an antibiotic used to treat UTI), 100 (mg) milligrams, 2 times a day, for 5 days. Review of the resident's September (MAR) Medication Administration Record, revealed the resident did not receive the morning dose of macrobid, as ordered by the physician, due to the medication not available on the 9/2, 9/3, 9/4, 9/5 and 9/6. The 9/6/15 at 9:20 AM nurse's note stated the resident wanted to sleep all morning, and needed constant verbal cues to wake up, eat breakfast, and drink fluids. The note stated the resident would wake up, and go right back to sleep, and the night shift staff reported he/she slept all night, and then continued to sleep all day. The 9/8/15 at 6:10 AM nurse's note stated the resident would not sit or stand up, and reported he/she did not feel well. At 2:29 PM, the note stated the resident had slept all morning and continued to sleep at this time.	{F 309}		

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{F 309}	Continued From page 6 The 9/8/15 at 2:00 PM physician's note stated the resident was seen for an acute visit due to nursing staff concerns of increased sleep and decreased oral intake. The resident had been treated for a UTI with macrobid since 9/2/15, but had not received the 2 times a day dosing until 9/7/15. The note stated the resident had a temperature of 100.9 degrees Fahrenheit. The physician ordered macrobid, 100 mg, 2 times a day, for 5 more days, and directed the staff to draw a (CBC) complete blood count, (CMP) complete metabolic count, and a (TSH) thyroid-stimulating hormone blood test), for fatigue and fever. The 9/8/15 at 4:50 PM nurse's note stated the resident had a small, yellow colored emesis (vomit), warm skin, and faint bowel sounds. The resident's vital signs included: blood pressure 181/96, pulse 116, and temperature of 100.7. The medical record revealed no documentation of the resident's voiding status. The 9/8/15 at at 5:00 PM nurse's note stated the staff notified the physician, who stated he/she would check the resident's laboratory results and call the facility back. The 9/8/15 at 5:13 PM nurse's notes stated the physician notified the facility that he/she wanted to admit the resident to the hospital. The hospital history and physical, dated 9/8/15, stated the hospital admitted the resident with the chief complaint of fever, nausea and vomiting. The history and physical also stated the resident had a high (WBC) white blood count (a blood test to determine infection) of 15.25 (normal range is	{F 309}		

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{F 309}	Continued From page 7	{F 309}		

3.5-10.5). The history and physical revealed the hospital admitted the resident for sepsis (a potentially life threatening complication of an infection), fever, and hypoxia (inadequate supply of oxygen).

The 9/11/15 hospital discharge summary stated the resident's discharge diagnoses were sepsis, likely secondary to urinary tract infection, resolved; fever, resolved; hypoxia, resolved; and hypertension, stable. The discharge summary stated the resident was started on (IV) (intravenous-through the vein), Rocephin (antibiotic medication), 1 gram, every 24 hours for sepsis secondary to to UTI, and the facility was to continue to monitor the resident for any signs of infection.

On 9/29/15 at 8:00 AM, observation revealed the staff propelled the resident in his/her wheelchair, to the dining room for breakfast. The resident appeared alert and he/she talked with the staff. Further observation revealed staff served the resident coffee, water and cranberry juice, and the resident was able to take sips of the drinks on his/her own, drinking all of the coffee, juice and most of the water.

On 9/29/15 at 1:45 PM, Nurse A stated the staff did not administer the macrobid antibiotic to the resident for a UTI as directed by the physician because the staff thought the medication was not available. Nurse A stated the resident appeared to sleep more than normal while he/she received the physician ordered antibiotic for a UTI.

On 9/29/15 at 2:10 PM, Nurse B verified he/she had not administered macrobid to the resident, as prescribed by his/her physician, for 4 mornings because he/she thought the medication was

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{F 309}	Continued From page 8	{F 309}		

unavailable. Nurse B verified he/she should have checked to see why the medication wasn't available, and should have reported it to the Director of Nursing. Nurse B stated the resident slept more and would not eat or drink very well.

On 9/29/15 at 2:45 PM, Nurse Aide C stated the resident had been more confused and sleepy, and didn't want to eat or drink much during the time he/she had a UTI.

On 9/29/15 at 4:00 PM, Administrative Nurse D verified the resident showed signs of increased sleepiness and decreased oral intake on 8/28 and by 9/6 the resident required constant verbal cues from the staff to wake up, eat breakfast, drink fluids, or sit or stand up. Administrative Nurse D stated he/she would have expected the staff to assess the resident and contact his/her physical about the decline in condition, before 9/8/15, when the staff reported it to the physician.

On 10/6/15 at 9:30 AM, Physician F's office nurse, Nurse E, stated Physician F verified the missed doses of the antibiotic macrobid, contributed to the resident's decline in condition, and resulted in admission to the hospital for sepsis (a potentially life threatening complication of an infection). Physician F stated he/she would have expected the facility's staff to notify him/her immediately when the resident showed a change in his/her condition.

The facility failed to thoroughly assess and monitor Resident #1 after the physician diagnosed the resident with a UTI, and he/she had a decline in his/her condition. The facility failed to seek physician involvement for 6 days for Resident #1, who did not receive antibiotics for a UTI as directed by the physician, demonstrated a

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{F 309}	Continued From page 9 physical decline and hospitalized for treatment of sepsis (a potentially life threatening complication of an infection), and UTI.	{F 309}		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This Requirement is not met as evidenced by: The facility had a census of 30 residents. The sample included 3 residents who were reviewed for medications. Based on observation, interview and record review, the facility failed to ensure the residents were free from any significant medication errors for 1 of 3 sampled residents. (#1) Findings included: - Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 9/22/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 11, which indicated he/she had moderate cognitive impairment. The MDS further indicated the resident had frequent urinary incontinence, required extensive assistance from the staff for transfers and toileting, and received antidepressant medications. The 1/13/15 and 9/11/15 care plan directed the staff to administer medications as ordered by the physician. The 8/27/15 at 8:48 PM, nurse's note stated the staff contacted the physician regarding the resident's condition of a "glassy look" to his/her face, blood pressure of 161/78 (normal is 120/80) and a rapid pulse of 107 (normal is 60-100).	F 333		

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F 333	Continued From page 10	F 333		

There was no documentation of the resident's temperature. The staff received an order from the physician for a urinalysis with culture and sensitivity if indicated. There was no documentation of the resident's temperature.

The urinalysis, dated 8/27/15, revealed the resident had a smalll amount of leukocytes (presence of infection), a trace of blood, and 11-15 white blood cells (normal is 0-5).

The 8/27/15 urine culture revealed the infection was susceptible to the medication nitrofurantoin (generic name for macrobid).

The 9/2/15 at 8:12 AM, nurse's notes stated the physician ordered macrobid (an antibiotic used to treat UTI), 100 (mg) milligrams, 2 times a day, for 5 days.

The 9/6/15 at 9:20 AM, nurse's notes stated the resident wanted to sleep all morning, and needed constant verbal cues to wake up, eat breakfast, and drink fluids. The note stated the resident would wake up, and go right back to sleep, and the night shift staff reported he/she slept all night, and then continued to sleep all day.

The 9/8/15 at 6:10 AM, nurse's note stated the resident would not sit or stand up, and reported he/she did not feel well. At 2:29 PM, the note stated the resident had slept all morning, and continued to sleep at this time.

The 9/8/15 at 2:00 PM, physician's note stated the resident was seen for an acute visit due to nursing staff concerns of increased sleep and decreased oral intake. The resident had been treated for a UTI with macrobid since 9/2/15, but had not received the 2 times a day dosing until

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F 333	Continued From page 11	F 333		

9/7/15. The physician ordered macrobid, 100 mg, 2 times a days for 5 more days, and directed the staff to draw a CBC (complete blood count), CMP (complete metabolic count), and a (TSH) thyroid-stimulating hormone blood test), for fever and fatigue.

On 9/29/15 at 8:00 AM, observation revealed the staff propelled the resident in his/her wheelchair to the dining room for breakfast. The resident appeared alert, and he/she talked with the staff. Further observation revealed the staff served the resident coffee, cranberry juice and water, and the resident was able to take sips of the drinks on his/her own, drinking all the coffee, juice, and most of the water.

On 9/29/15 at 1:45 PM, Nurse A stated the staff had not given the resident his/her antibiotic for several mornings because they thought the medication hadn't been delivered from the pharmacy.

On 9/29/15 at 2:10 PM, Nurse B stated he/she did not give the resident his/her antibiotic for several mornings when he/she worked because he/she thought the medication had not been delivered to the facility by the pharmacy. Nurse B stated he/she should have checked with the pharmacy, and notified the Director of Nursing.

On 9/29/15 at 4:00 PM, Administrative Nurse D stated the staff did not administer the resident's antibiotic as the physician ordered. Administrative Nurse D stated the staff should have notified him/her, and contacted the pharmacy about the medication.

On 10/6/15 at 9:30 AM, Physician F's office nurse, Nurse E, stated the physician verified the

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F 333	Continued From page 12 missed doses of the antibiotic macrobid, contributed to the resident's decline in condition, and resulted in admission to the hospital for sepsis (a life threateing complication of an infection). Physician F stated he/she would have expected the facility's staff to notify him/her immediately when the resident showed a change in his/her condition. The facility failed to ensure Resident #1 was free from significant medication error, when the staff did not administer an antibiotic to treat a UTI, as ordered by the physician, and the resident missed 5 of the 10 scheduled doses of the medication.	F 333		