STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N073002	A. BUILDING: _____ B. WING _____	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LARNED	714 W 9TH STREET LARNED, KS 67550

(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 of the above named assisted living facility on 4/24/18 and 4/25/18.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 18 residents. The sample included 3 residents. Based on observation, record review and interview the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of each resident and were in accordance with the functional capacity screening and negotiated service agreement for 2 of 3 sampled residents (#502 and #503) regarding falls and side rail use. Findings included: - Record review for resident #502 revealed an admission date of 9/14/17 with diagnoses of	S3155		

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

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S3155	Continued From page 1 hypertension, history of CVA (stroke), frequent falls, weakness, atrial fibrillation and frequent urinary tract infections. The functional capacity screen dated 9/14/17 indicated the resident required physical assistance with dressing, toileting, walking or mobility. He/she required physical assistance when transferring, used a wheelchair and was at risk for falls. The negotiated service agreement (NSA)/health service plan (HSP) dated 9/14/17 included for staff to assist the resident in/out of the tub/shower, moderate assistance with dressing, assist to/from the toilet. Staff should provide physical assistance with guided maneuvering of limbs or weight bearing and required physical assistance of 1 staff to walk safely. The NSA included a sheet titled Fall Intervention Plan which included a listing of 37 different interventions a licensed nurse could use to prevent further falls. The sheet included the following additions: 9/14/17 Physical Therapy (PT) and Occupational Therapy (OT) 10/9/17 item #7 which was monitor closely post fall period 10/14/17 Keep walker close to patient 4/7/18 item #7 monitor closely post fall period (repeat of previous intervention) Review of the fall risk assessments revealed 9/14/17 score of 10 with 10 or higher meaning high fall risk, 10/9/17 score of 10, 10/14/17 score of 10, (no assessment with 12/6/17 fall see below) and 4/7/18 score of 10. Review of the nursing notes revealed the following:	S3155		

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S3155	Continued From page 2 10/9/17 at 9:15 PM resident was reaching for mentholatum and rolled out of bed onto the floor. No apparent injuries noted. The note included vital signs and notification of family. The note did not include a fall intervention to prevent further falls. The notes lacked any evidence of monitoring the resident closely post fall period with the next note dated 10/14/17. 10/14/17 (no time listed) received report the resident had fallen and walker out of reach. Vital signs in normal limits and no injuries. Patient denies (unreadable)/pains. Physician and family notified. Patient stated he/she hit his/her head. No further orders. Watch patient closely for changes. The note did not include a fall intervention to prevent further falls. The notes lacked any evidence of monitoring the resident closely for changes with the next note dated 11/12/17. 11/12/17 at 4:00 PM no concerns at this time. 12/6/17 at 12:00 PM at approximately 11:20 AM the resident pushed his/her call button. When certified medication aide (CMA) A entered the resident's room he/she observed the resident on the bathroom floor on his/her back. CMA A called for the nurse who observed the same. The resident was bleeding from a large goose egg on his/her middle forehead and below his/her eye socket on the right side from his/her glasses where there was a puncture mark ... The nurse assisted the resident up and in to a wheelchair. The resident was transported to the emergency room (ER) for further evaluation. The area on his/her forehead was first cleansed with wound cleanser and a pressure dressing applied wrapped with Coban (a self-sticking dressing).	S3155		

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S3155	Continued From page 3 12/6/17 at 2:00 PM the resident returned from the ER where they glued the laceration on the middle of his/her forehead and placed Steri-strips (self-sticking strip with thread through it to hold skin together) in the same area. When the resident was asked why he/she did not wait for staff assistance he/she reported being sick to the stomach and needing the bathroom quickly and did not want to be incontinent. The nurse educated the resident on the importance of calling for assistance at all times even if he/she might have an incontinent episode. The resident verbalized understanding and stated he/she would call for assistance in the future. 4/7/18 (unreadable time) reported non-injury fall. Denies pain or concerns. No evidence of injury. Vital signs within normal limits. Stable. Notified family. The note lacked causal factors or interventions to prevent further falls. The Fall Intervention Plan included monitor closely post fall period. The notes lacked any monitoring with the next note dated 4/10/18. The record lacked any evidence a nurse updated the NSA or HSP with the resident's fall on 12/6/17 and intervention #7 would only prevent future falls during the post fall period and not a long-term intervention to prevent further falls. Interview on 4/24/18 at 3:15 PM with licensed nurse B confirmed a lack of monitoring after the 10/9/17 and 10/14/17 falls. He/she confirmed the NSA/HSP lacked fall interventions for the 12/6/17 fall and the required fall risk assessment was not completed after the 12/6/17 fall. The facility's policy titled Fall Management dated 2014 directed staff to complete a fall risk assessment if the FCS indicated or the resident	S3155		

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S3155	Continued From page 4 had fallen. If a fall occurs update the Fall Intervention Plan accordingly. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and in accordance with the functional capacity screening and negotiated service agreement regarding fall prevention. - Record review for resident #503 revealed an admission date of 4/22/16 with diagnoses of diabetes mellitus and history of right hip fracture. The annual Functional Capacity Screen dated 4/20/18 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating. He/she had impaired short-term memory and used a walker. The Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 4/20/18 indicated the resident required supervision, mild cognition impairment of short-term memory loss and may need some initial guidance. The NSA directed certified staff would assist resident with all transfers due to unsteady gait. included the resident needed assistance of 1 staff for transfers. Under other ...resident used a hospital bed provided by an outside source. The bed rails are not used as a form of restraint. The record lacked an assessment to verify the rail was not a restraint, the resident used the rail safely and the rail design/attachment/gaps and mechanisms were safe. Observation on 4/24/18 at 3:45 PM revealed half rails attached on both sides of the resident's bed.	S3155		

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S3155	Continued From page 5 Interview on 4/24/18 at 3:45 PM with certified medication aide (CMA) C revealed the resident slept in the bed sometimes in the afternoon or at night. He/she used the bed rails to help him/her get out of the bed. CMA C confirmed the bed rails were used at times. Interview on 4/24/18 at 3:48 PM with licensed nurse B confirmed he/she had not completed a side rail assessment which included the above specifics. A request for a policy regarding side rail use on 4/24/18 revealed the facility did not have a policy. The administrator failed to ensure a nurse provided or coordinated the provision of necessary health care services which met the needs of resident #503 related to side rail use.	S3155		