STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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 an abbreviated survey for complaints #157260 and #153004 of the above named facility conducted on 11/03/2020, 11/04/2020, 11/05/2020, 11/09/2020, 11/10/2020 and 11/12/2020.	S 000		
S3171 SS=G	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: KAR 26-41-204 (i) The facility reported a census of 14 residents. The sample included 3 residents and 2 focused review. Based on observation, interview and record review the operator failed to ensure all health care services were provided in accordance with acceptable standards of practice for 1 (#309) sampled resident in regards to prescribed daily weights, transcription of a medical care providers wound dressing orders and prescribed equipment for treatment of lower extremity edema. Resident #309 developed open wounds on his right lower leg related to edema and circulation. He was hospitalized for sepsis from bilateral lower leg cellulitis and subsequent heart attack on 05/10/2020. Upon return on 06/03/2020 he continued with wounds to the right lower leg. On 06/17/2020 medical care provider H prescribed daily dressing same as orders from	S3171		

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
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 1	S3171		

skilled nursing facility and daily weights. The daily weights reflected frequent refusals without evidence of educating the resident or responsible party of the medical need for the weights or evidence of reattempts. On 06/24/2020 he weighed 215, refused on 06/25/2020 and on 06/26/2020 his weight was up 5 pounds (220) without evidence of notifying the medical care provider. The only weights recorded on the July 2020 Medication administration record (MAR) were on the 6th and 7th. On 07/14/2020 the medical care provider made a visit to the facility and determined the resident's legs were much worse and sent the resident to the emergency room (ER). From the ER he admitted to the hospital with cellulitis and returned on 07/19/2020. He had cellulitis again on 09/09/2020 with antibiotic treatment at the facility, he continued with edema and inconsistent weight monitoring, and a medical care provider prescribed on 09/24/2020 a "FlexiTouch" (intermittent pneumatic compression device for treatment of lymphedema and nonhealing venous leg ulcers) as of 11/03/2020 at 10:45 AM the record lacked any evidence of a licensed nurse implementing this prescribed treatment.

Findings included:

- Record review for resident #309 revealed an admission date of 08/15/2019 with diagnoses of congestive heart failure, hypertension, Parkinson's, Alzheimer's, chronic back pain and history of knee surgery.

The admission functional capacity screening (FCS) dated 08/16/2019 identified the resident with impaired short-term memory, memory recall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 2	S3171		

and decision making. He required physical assistance with bathing, dressing and medication/treatment management. He used a walker for mobility with supervision. After his heart attack, hospitalization and skilled therapy his FCS dated 08/11/2020 indicated he had impaired short-term memory and decision making, independent with transferring, toileting, walking and supervision with bathing and dressing. He used a walker and a wheelchair. He continued to need physical assistance with medication/treatment management.

The admission negotiated service agreement and service plan (NSA/HSP) dated 08/15/2019 included the following services provided by the facility: staff assist with bathing twice a week, staff assist with donning and doffing clothes throughout the day, staff to ensure hygiene and grooming and staff assist with toileting as needed. He could transfer and walk independently with a walker. Any significant changes will be reported to the primary care provider by the facility nurse or on-call nurse. All by mouth medications and all ordered treatments will be administered by facility (no entity identified) certified medication aide (CMA) unless otherwise specifically ordered by the medical care provider. Routine monthly vital signs, weekly weights and ordered lab will be obtained for all residents in our facility. The admission NSA/HSP lacked any information about an outside provider but an addendum dated 09/14/2019 indicated a discontinuation of Home Health services. The NSA/HSP lacked any revisions related to altered skin, interventions prescribed to monitor the CHF and edema or the addition of an outside provider for wound management as ordered on 04/16/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 3 The NSA dated 08/11/2020 included services of staff assistance with bathing, PRN (as needed) assistance with dressing, facility management of medications and dressing changes, as well as Home Health for wound care. The health service plan dated 08/11/2020 directed staff to assist with bathing due to unsteadiness from Parkinson's and resident will ring call bell when he is ready. He will call for assistance to dress the lower half of his body. He would ring for assistance with mobility, toileting and used a walker to transfer. Staff to encourage him to follow a low sodium diet and up to 2 liters of fluids a day but resident is non-compliant with the diet. Meals and snacks are prepared and served to the resident by staff. Under well-being licensed nurse E marked him as unstable chronic conditions and noted he was non-compliant with diet/wound care/personal care at times contributing to flare-ups. Primary care physician will be notified of any changes in health status. Facility nurse/CMA will provide all medication/treatment management. Resident is alert and oriented x 3 (person, place, time) but very forgetful. Review on 11/03/2020 at 11:45 AM of the resident progress notes between 09/13/2019 and 10/29/2020 at 1:00 PM (last entry) revealed the following entries: On "02/20/2018" (note is between 02/17/2020 and 02/27/2020 entries so probably correct date 02/20/2020), received order from medical care provider to obtain daily weights for diagnosis of congestive heart failure, notify of weight greater than 3 pounds overnight or greater than 5 pounds in 1 week.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 4 On Saturday 02/29/2020 at 8:30 AM licensed nurse E noted the resident to have increased leg swelling, redness and warmth. She was unable to reach the medical care provider and the on-call recommended ER visit which the resident refused. She educated the resident on the risk of waiting and again he refused ER. She instructed staff on signs and symptoms to monitor and report to the nurse. The record lacked any evidence of further follow-up until the next entry on 03/05/2020 at 8:30 AM medical care provider made in-facility visit and prescribed an antibiotic, increase the diuretic, continue daily weights, utilize ace wraps and send to ER if short of air or chest pain. Medical care provider again gave perimeters for when to call about weight gain same as before. The record lacked evidence of monitoring or follow-up on his edema until the next entry dated 03/25/2020 at 12:20 PM licensed nurse F notified the medical care provider of the resident having increased edema in bilateral lower extremities (BLE) of 3+ pitting (a swollen part of the body which leaves a dimple after pressed for a few seconds. 1+ as barely detectable, 2+as slight indentation resolved in 15 seconds, 3+ deeper indentation resolved in 30 seconds and 4+ takes greater than 30 seconds to resolve). She noted the legs were weeping but no redness or warmth noted today. On 03/31/2020 at 8:00 AM licensed nurse E received orders for Mupirocin ointment to open areas on legs then wrap daily from toes to knees. The note lacked any description about the open areas. On 04/16/2020 at 5:00 PM licensed nurse E wrote she received orders for wound care to BLE, admit resident to Home Health for wound care and start when supplies arrive. The note lacked any description, size, open area or not of	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 5 the wounds. The first Home Health visit note dated 04/29/2020 identified 7 open areas total to both legs (3 on the left leg and 4 on the right leg) of various sizes. Resident progress notes and Home Health visit notes between 04/16/2020 and 05/06/2020 lacked any evidence of the resident refusing treatments. Then on 05/06/2020 at 11:00 AM licensed nurse E wrote; resident had removed dressing every day on his own and self-applied vitamin A & D ointment to the open wounds (the record lacked an order for this or a self-medication assessment). She provided education on the current orders for wound care. He stated having increased pain in the BLE, she noted redness on the left lower leg with warmth and tenderness. She indicated the resident had refused daily weights, but she obtained a weight at 226 pounds (base line weight for him approx. 215) and she called the medical care provider who wanted the resident to go to the ER. Upon return the same day 05/06/2020 with orders to increase the diuretic. The next entry was dated 5 days later on 05/11/2020 at 8:00 AM which indicated on 05/10/2020 at 6:20 PM the resident complained of chest pain and had a pulse of 180 and was sent to the ER. He was admitted for sepsis from BLE cellulitis and a heart attack. Home Health visit note by licensed nurse D dated 05/07/2020 identified 3+ pitting edema. In the comments she noted his refusal of treatment to the legs and she spoke with him about the treatment, purpose of Home Health and if not following doctor orders he may be taken off of Home Health services. She indicated she left a message with the primary care provider and planned another visit on 05/09/2020. The record lacked any information of a follow-up with the	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 6	S3171		

primary care provider after the message left. The 05/09/2020 Home Health visit note indicated the resident had 2+ edema in BLE, daily pain but not constant of a 4 on scale of 1-10 and no indicator of treatment refusal or comments.

Review of the medication administration record (MAR) for February 2020 beginning on 02/21/2020 mostly unreadable weights. On the 25th it looked like a weight of 215 pounds, unreadable on 02/26/2020 and on 02/27/2020 a weight of 227 and no evidence of calling the medical care provider.

The March 2020 MAR had almost all days with a weight, some were not readable, which were mostly around 226 pounds. On 03/19/2020 after a diuretic increase and start of antibiotic his weight went down to 202 on 03/20/2020. Unable to read 03/21/2020 and on 03/22/2020 his weight was up 4 pounds with no evidence of notifying the medical care provider. On 03/23 and 03/24/2020 the weight was 207 pounds then on 03/25/2020 his weight was difficult to read but looked like 226 pounds. The medical care provider was notified and increased the diuretic again.

The April 2020 MAR had a weight recorded for every day with most of them readable. The weights ranged from 213 to 218 until 04/26/2020. On 04/26/2020 he weighed 215 pounds and on 04/27/2020 he weighed 228 pound (a 13-pound increase) and no evidence of notifying the medical care provider. His weight remained elevated through the rest of the month.

The May 2020 MAR had a weight on the 1st of 228 pounds, the 2nd through the 5th marked as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 7	S3171		

refused without any evidence of reattempts. On the 6th he presented with a pain in his legs, redness, warmth and tenderness with a weight of 226 and the medical care provider was finally notified and ordered for the resident to go to the ER. His weight remained elevated through the 10th with only 2 pounds lost despite the increased diuretic prescribed in ER and no evidence of consulting with the medical care provider until 05/10/2020 (other than the Home Health visit note on 05/07/2020 with a message left) when he went to the ER again and was admitted for sepsis from BLE cellulitis and heart attack.

He readmitted to the facility on 06/03/2020 according to the note dated 06/03/2020 at 1:30 PM. He had a kerlix dressing to the right lower extremity (no evaluation of the area noted) ...Home Health will see tomorrow.
The first entry by Home Health dated 06/04/2020 was a resumption of care which noted no open areas at this time.
The 06/07/2020 home Health visit note included the previous 7 areas with the same measurements but marked as closed. However, 4 areas were marked with scant purulent (milky in appearance and almost always a sign of infection), 2 had small amount of purulent drainage and 1 had scabbed areas.
The next entry was dated 06/17/2020 at 2:00 PM licensed nurse E recorded the medical care provider made an in-house visit and received orders for daily wound care of wound cleanser, pat dry, apply Aquacell AG (alginate) to open areas only, cover with 4 x 4 gauze pad as needed for padding, Optilock (an absorbent polymer cores dressing) for drainage and kerlix. Double Tubi-grips to BLE put on in AM and off

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 8	S3171		

HS (bedtime). The record lacked evidence of the resident being encouraged or educated on leg elevation to address the edema and or refusals.

The June 2020 Medication administration record (MAR) reflected multiple days of refusal to be weighed without evidence of reattempts or education on the risk associated with the refusal (12 times out of 30 with 3 days being blank). The record had evidence of communication with Medical care provider H about the a weight on 06/24/2020 via a lab report. The June 2020 MAR had an entry for the Double Tubi-grips starting 06/17/2020 to put on at 8:00 AM and off and bedtime. The 19th, 20th and 21st were unreadable and the 27th, 28th, 29th and 30th appeared to have the initials circled as an indicator of not putting them on with no explanation on the MAR variance sheet or in the resident progress notes.

Record review of the wound care notebook revealed a plastic sleeve which held the current medical care provider's orders and a single sheet titled Wound Care Sheet. The wound care sheet included the date and initials to signify the dressing change was completed between 06/17/2020 and 07/14/2020. The sheet indicated during the timeframe the resident refused 5 times out of 28 days without any evidence of another attempt or education of the health risks associated with the refusal. The Home Health visit notes between 06/17/2020 and 06/21/2020 indicated the resident had 3-4+ pitting edema, some pain and no indicators of treatment refusal. On 06/22/2020 the wound measurements were 13 cm by 9 cm and depth of 0.1 cm with small amount of purulent drainage. Of note: the comments indicated he refused the Tubi-grip and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 9	S3171		

licensed nurse D used ace wraps instead. She also indicated he had refusal to be compliant with his medical regimen which put him at risk for increased complications but did not indicate whether she educated the resident on this. The resident progress note dated 06/22/2020 indicated medical care provider H was in the facility that day and changed the resident's treatment order. On 06/27/2020 licensed nurse E noted 3+ edema, resident report of daily pain with an open blister and same measurement but now with moderate purulent drainage and there was no dressing on the wound when she arrived. She indicated the resident tolerated the treatment well with no indicator of refusal. The resident progress notes lacked any notes on 06/27/2020 to indicated medical care provider H was notified of the change in drainage and report of pain. On 06/28/2020 his edema was 2+ with pain less than daily and ace wraps used due to refusal of Tubi-grips. On 07/01/2020 wound noted to have macerated surrounding tissue and resident tolerated treatment well with no indicators of treatment refusal. The medical care provider ordered an antibiotic for possible cellulitis on 07/02/2020. On 07/04/2020 the resident had 2+ edema with decreased skin turgor, pain all the time at level 9 on scale of 1-10, wound measurements the same, large amount of serosanguinous (blood, blood serum and yellowish fluid mixed) drainage, macerated surrounding tissue and the resident tolerated the treatment well with no indicator of refusal. The resident progress note had no evidence of informing the medical care provider of the change in pain or drainage. The last Home Health visit note for the time frame of 06/17/2020-07/14/2020 indicated on 07/10/2020 by licensed nurse D noting 2+ edema, pain daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 10	S3171		

but not constant, good skin turgor and indicated the resident was non-compliant with diet of low sodium and fluid restriction. She indicated the medical care provider was aware. She noted the resident refused to have his legs covered or use of ace wrap. The resident progress notes went from 07/08/2020 - 07/14/2020 with no information about the resident's skin condition, edema, compliance with prescribed cares or education of associated risks.

The resident progress note dated 07/14/2020 indicated the medical care provider made an in-facility visit, noted the legs were much worse and had the resident sent to the ER where he was admitted for cellulitis and failed outpatient therapy. He readmitted to the facility on 07/19/2020 at 1:00 PM and licensed nurse G recorded wound measurements of right lower leg 15 by 15 (unreadable), left lower leg 10 cm by 3 cm with orders for a daily dressing change to cleanse the wound with normal saline, pat day, apply Xerofoam (a petrolatum based dressing) to wound beds, cover with 4 by 4 and cover with Kerlix. The note indicated she recorded the order on the paper MAR. Review of the paper July 2020 MAR revealed no such order.

The July 2020 MAR (07/01/2020-07/14/2020) only had staff initials for application of the Double Tubi-grips on the 3rd and 4th with all other days blank. From 07/19/2020 -07/31/2020 the only days initialed for application of the Tubi-grips were the 20th, 24th and 27th. However, nearly every day was initialed for removal at bedtime even the days he was in the hospital. The daily weights were only recorded on the 7th and 8th with the 1st as refused and no evidence of reattempts. All other days were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 11 blank through 07/14/2020 and 07/19/2020 through 07/31/2020. The August 2020 MAR lacked any staff initials for application of double Tubi-grips but had initials of removal. The September 2020 MAR (copies provided on 11/03/2020 by licensed nurse E) lacked any entry for the double Tubi-grips order and review of the medical care provider's order revealed no order to discontinue. Review of the September and October 2020 daily weight flowsheet revealed multiple refusals charted with no indicator of reattempts or notification of the medical care provider of the refusals. According to the resident progress notes during August, September and October the resident reported having lots of leg cramps and pain with medication changes made (pain meds, diuretics and antibiotics). The record lacked any information related to resident not sleeping in a hospital bed so he could elevate his legs as prescribed on 06/04/2020 and no information about staff trying to get the resident to elevate his legs when seated in the recliner. On 09/24/2020 the medical care provider made an in-facility visit and increased the diuretic, ordered an antibiotic and "FlexiTouch" (intermittent pneumatic compression device for treatment of lymphedema and nonhealing venous leg ulcers) to be applied to both lower legs for 30 minutes every day. The September 2020 MAR lacked this order, the home health nurse visits lacked information about this order and the resident progress notes lacked any information about this order. On 09/30/2020 the medical care provider wrote	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 12 the following wound care orders: discontinue the Xerofrom dressings and start, cleanse wound daily with wound cleanser or soap and water, then pat dry, cover open/draining wounds with Silver alginate daily and PRN (as needed) if soiled, cover the dressing with ABD pads for drainage, utilize double compression wrap (Coban 2 layer lite compression bandage or similar) to the right lower leg over the dressing starting at the base of the toes and wrap upwards to below the knee, change daily with dressing changes. Utilize double tubigrip to the left lower leg daily (on AM/off HS bedtime) for edema, starting at the base of the toes to below the knee. Fax summary of patient compliance with the wound care weekly ... (number listed) and the current weights with a weekly compliance summary. The medical care provider between 09/30/2020 and 10/08/2020 prescribed narcotic pain medication before dressing changes, changed the antibiotic, started vitamin D, asked the facility to set-up appointment with a neurosurgeon for chronic low-back pain and to have a weekly fax of the weights and patient compliance with wound care. The first indicator of the information being communicated to the medical provider was on 10/19/2020 (19 days after the order was noted by licensed nurse E). On 10/29/2020 the medical care provider wrote orders for antibiotic, increase in the diuretic, lab work up, restart of lidocaine patches for the back pain, FlexiTouch to BLE x 30 minutes daily, alert the provider if patient refused and daily weights with a faxed report of weights and compliance to the provider weekly. The October and November 2020 MAR lacked the order for the FlexiTouch.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 13 Observation on 11/03/2020 at approximately 10:45 AM revealed the resident in his room seated in his lift recliner with the back of the recliner almost all the way elevated and his feet were on the floor. His right leg had ace wrap on it with visible dark red skin at the top below the knee and the left leg was bare without any dressing or Tubi-grips. In talking with the resident, he was able to state where he was, identified spouse in the room, what he was watching on the television, that the hospital bed in the room was intended from him to use. He said the nurses changed his bandage on his leg but denied need for elevation or any use of the FlexiTouch after explanation of what the equipment would look like. His family member also in the room declined to comment about his legs and/or treatment merely stating he does what he wants. Communications with medical care provider H on 11/03/2020 confirmed she did not get weekly reports of daily weights as ordered, did not get reports of any non-compliance as ordered and indicated she would be told sporadically through on-site visits. She expressed concerns about the daily weight refusals and no evidence of reattempts or education. She felt this was very important to manage his overall cardiac health and edema. She reported the facility failed to obtain and implement the prescribed FlexiTouch as ordered on 09/24/2020 which would help the resident greatly and decrease the need for long-term high dose diuretics. She reported reordering it again on 10/29/2020 and upon a follow up visit she noted the device had still not been implemented. When she followed up on it with the facility nurse who reported the resident	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 14	S3171		

refused. She indicated she expressed to the facility nurse the importance of the resident to use the device, the resident had dementia and would need encouragement/education and if the device was never in the room how could staff apply the device.

Interview with licensed nurse D and E on 11/03/2020 and 11/05/2020 confirmed the documentation in the resident's record lacked evidence of consistent weight monitoring as ordered, lacked evidence of reattempts at the daily weights when the resident refused and/or education each time. They confirmed the order for the FlexiTouch on 09/24/2020 and 10/29/2020 with no evidence of transcription of the order to the MAR. They provided no evidence of when the equipment arrived, attempts to apply and/or resident refusals with reeducation.

The facility's policy and procedure titled, Medication Administration dated 11/05/2009 directed it is the responsibility of the licensed nurse who received a new order or medication change to correctly transcribe the new order or medication change on the MAR. Order. ... update the resident's files and route copies to Home Health when appropriate.

The operator failed to ensure all health care services were provided in accordance with acceptable standards of practice for this resident regarding prescribed daily weights, transcription of a medical care providers wound dressing orders and prescribed equipment for treatment of lower extremity edema. The resident developed open wounds on both his lower legs related to edema and circulation. He was hospitalized for sepsis, cellulitis and had a heart attack on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3171	Continued From page 15 05/10/2020. Upon return on 06/03/2020 he continued with wounds to the legs. The daily weights reflected frequent refusals without evidence of educating the resident or responsible party of the medical need for the weights or evidence of reattempts. On 06/24/2020 he weighed 215, refused on 06/25/2020 and on 06/26/2020 his weight was up 5 pounds (220) without evidence of notifying the medical care provider. The only weights recorded on the July 2020 MAR were on the 6th and 7th. On 07/14/2020 the medical care provider made a visit to the facility and determined the resident's legs were much worse and sent the resident to the emergency room (ER). From the ER he admitted to the hospital with cellulitis and returned on 07/19/2020. He had cellulitis again on 09/09/2020 with antibiotic treatment at the facility, he continued with edema and inconsistent weight monitoring, and a medical care provider prescribed on 09/24/2020 a "FlexiTouch" (intermittent pneumatic compression device for treatment of lymphedema and nonhealing venous leg ulcers) as of 11/03/2020 the record lacked any evidence of a licensed nurse implementing this prescribed treatment.	S3171		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3200	Continued From page 16 recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (a) The facility reported a census of 14 residents. The facility identified all residents with facility managed medications. The sample included 3 residents and 2 focused record reviews. Based on record review and interview the administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for 2 of 3 residents sampled for medication review (#232 and #309). Findings included: - Record review for resident #232 revealed an admission dated of 01/26/2011 with diagnoses of diabetes, dementia, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The annual functional capacity screen dated 03/26/2020 identified the resident with impaired	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3200	Continued From page 17	S3200		

cognition in all aspects. She was unable to manage her own medications/treatments.

The negotiated service agreement and service plan dated 03/26/2020 directed all by mouth medications and ordered treatments would be administered by facility (lacked entity identification) or certified medication aide, unless otherwise specifically ordered by the medical care provider. Insulin to be administered by home health nurse when facility nurse was unavailable.

Review of the signed medical care provider's orders dated 09/28/2020 revealed an order for accu-checks (blood glucose monitoring), Levothyroxine 0.05 milligrams 1 tablet by mouth on Monday through Friday and 2 tablets on Saturday and Sunday, Lasix 40 milligrams by mouth daily for CHF and Novolog 10 units subcutaneously every day at noon.

Review of the October 2020 medication administration record (MAR) revealed multiple dates/times without any staff initials to indicate the accu-check was completed. The standard of practice when medications are ordered for different doses on different days included the MAR being marked with an X on the days when not to give. The October 2020 MAR had Levothyroxine with 2 separate places for the Monday through Friday (Mon-Fri) doses and the Saturday/Sunday doses (Sat/Sun). The one for Sat and Sun lacked any X placed to alert staff not to administer and the Mon-Fri had Xs on the days for Sat and Sun. Staff initialed every day on the entry for the 2 tablets except the 2nd and the 30th which had an X written in and staff circled their initials on the 3rd thru the 7th, the 22nd and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3200	Continued From page 18 23rd, the 26th, 28th and 29th. There was no explanation on the medication variances sheet which was blank. The Lasix entry had pre-printed Xs of not to administer Mon-Fri this entry lacked a correction but staff initialed on the next row. The Novolog 10 units for the noon dose lacked initials on the 21st to indicate the medication was administered. Interview with licensed nurse E on 11/05/2020 confirmed the preprinted Xs on the October 2020 MAR were misprinted and she failed to rewrite the entries to give clear directions to the CMAs on when to administer the Levothyroxine and Lasix. She also indicated staff were expected to initial the MAR when they performed the accu-check or administered any medications. If the medication or accu-check was not administered or any other variance then the variance sheet should include a reason and actions taken. The facility's undated policy and procedure for MAR directed appropriate personnel (CMA, licensed nurses) must sign the MAR following administration of any and all medications. This will be monitored by the operator/nurse at least 4 times weekly. Any discrepancies will be brought to the attention of appropriate personnel i.e. person or persons involved in the administration ... The administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for this resident regarding Levothyroxine, Lasix, Novolog and accuchecks.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3200	Continued From page 19	S3200		

- Record review for resident #309 revealed an admission date of 08/15/2019 with diagnoses of congestive heart failure, hypertension, Parkinson's, Alzheimer's, chronic back pain and history of knee surgery.

The annual functional capacity screening dated 08/11/2020 identified the resident with impaired short-term memory and decision making. He required physical assistance with medication/treatment management.

The negotiated service agreement dated 08/11/2020 included facility management of medications and directed all by mouth medications and all ordered treatments will be administered by facility (no entity indicated) or certified medication aide (CMA) unless otherwise specifically ordered by the medical care provider.

The health service plan dated 08/11/2020 directed staff the facility nurse/CMA will provide all medication/treatment management. Resident is alert and oriented x 3 (person, place, time) but very forgetful.

Review of the signed medical care provider's orders and compared to the September 2020 medication administration record (MAR) revealed the following:
The order for Requip (a medication for restless/painful legs) 3 milligrams (mg) by mouth at bedtime (HS) for Parkinson's had staff initials on all days with those initials circled between the 12th and 28th (17 days). The medication variance sheet included 10 entries of the Requip not being given and indicated it was on order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3200	Continued From page 20 The sheet lacked any information of CMAs alerting the nurse to the medication not being available. On 2 of the days (23rd and 24th) the resident received Tylenol 500 mg 2 tablets by mouth for leg pain. Review of the resident progress notes between 01/01/2020 and 10/01/2020 revealed the resident experienced multiple episodes of severe lower leg edema, weeping and open wounds which developed cellulitis (bacterial infection of the skin appearing red, swollen, hot and tender). He reported an increase in leg cramps on 09/01/2020 and again treated for cellulitis on 09/09/2020. The notes between 09/12/2020 and 10/01/2020 lacked any evidence of the resident not receiving the Requip, notification of the medical care provider or if any other actions were taken. Review of the signed medical care provider's orders and compared to the October 2020 MAR revealed the following: Lisinopril 10 mg by mouth daily for hypertension was initialed by staff on all days with days between the 6th and the 20th circled (15 days). The medication variance sheet had 1 entry on 10/06/2020 of Lisinopril on order. The sheet lacked any information of CMAs alerting the nurse to the medication not being available. Review of the resident progress notes between 10/01/2020 and 10/19/2020 revealed no entries of the medical care provider being notified of the medication unavailable. On 10/19/2020 (14 days since first missed dose) at 8:00 AM licensed nurse E wrote she received a call from the guardian for the resident who reported the medication went to her house due to a change of address. The medical care provider order and October	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3200	Continued From page 21 2020 MAR included Omeprazole 40 mg 1 tablet daily in the morning for 90 days which ends on 10/08/2020. The MAR had staff initials on all days through the 19th except for the 15th which was blank. None of the initials were circled and the medication variance sheet lacked any information about Omeprazole. The orders and MAR also included Pepcid 20 mg twice a day for 90 days with an end date of 10/08/2020. The MAR had staff initials for both times of day through the 13th to indicate the medication had been administered. Beginning on the 14th staff circled their initials. The medication variance sheet indicated the Pepcid was not given but was ordered on the 15th, 16th, 17th and 18th. Interview with licensed nurse E on 11/05/2020 confirmed the resident went without the Requip as indicated on the September 2020 MAR. She confirmed the record lacked evidence of consulting with the medical care provider when the medication remained unavailable for more than a day or so. She confirmed the resident went without the Lisinopril as indicated on the October 2020 MAR because the medication went to the wrong address and the record lacked evidence of notifying the medical care provider of the unavailable medication. She confirmed the October 2020 MAR was initialed by staff as administering the Omeprazole and Pepcid past the stop date of 10/08/2020. The facility's undated policy and procedure for MAR directed appropriate personnel (CMA, licensed nurses) must sign the MAR following administration of any and all medications. This will be monitored by the operator/nurse at least 4 times weekly. Any discrepancies will be brought to the attention of appropriate personnel i.e.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3200	Continued From page 22 person or persons involved in the administration ... The administrator/operator failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for this resident regarding Requip, Lisinopril, Omeprazole and Pepcid.	S3200		
S3245 SS=F	26-41-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (a) The facility reported a census of 14 residents. The sample included 3 resident and 2 residents for focused review. Based on observation, interview and record review the administrator/operator failed to ensure the provision of a sufficient number of qualified personnel to provide each resident with services and cares in accordance with that resident's functional capacity screening, health care service plan and negotiated service agreement for 4 of 5 sampled residents (#232, #289, #323 and #411)	S3245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3245	Continued From page 23	S3245		

regarding the need for a 2 person assistance with transfers. This deficient practice had the potential to affect all residents if the 1 staff member would be tied up with a resident needing a 2 person transfer.

Findings included:

- On 11/03/2020 licensed nurse E provided the resident roster which identified 3 residents as needing 1 to 2 staff for assistance with transfers.

Interview on 11/03/2020 at 11:27 AM with licensed nurse E revealed she marked the resident as 1 to 2 person transfers because the residents would have bad days with their ADL (activities of daily living) and for safety. She indicated none of the resident's required a mechanical lift.

Interview on 11/03/2020 licensed nurse/operator D reported routine staffing consisted of 2-3 staff on the day shift with 1 who worked 12 hours and would be there until 7 or 8 PM along with the 1 assigned evening staff. After 8 PM would be the 1 staff. The over night shift only had 1 staff 2-3 times a week.

Review of the facility's staffing schedule for June through November 2020 revealed multiple times where only 1 staff was scheduled on the overnight shift.

Record review of the facility's evacuation/emergency drills revealed it was last conducted on 11/20/2019 and indicated two staff participated in the evacuation of 14 residents which took 10 minutes and 32 seconds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3245	Continued From page 24	S3245		

Interview on 11/05/2020 at 11:00 AM with licensed nurse/operator D revealed she had not held another evacuation since the decrease in staff to only 1 several times a week on the overnight shift. She indicated the staff went to 1 a couple times a week beginning in June 2020. She confirmed the residents identified on the resident roster needed one to two staff assistance with transfers and would always need two staff in the facility to provide the transfer assistance in an emergency.

Review of the facility's, undated, disaster and emergency preparedness plan revealed the facility would provide sufficient staff to promptly take residents who require assistance to the outside or to a point of safety in an emergency.

- Record review for resident #232 revealed an admission date of 01/26/2011.

The annual functional capacity screen dated 03/26/2020 revealed the resident had cognitive deficit in all aspects and lacked the ability for any self-performance in bathing, dressing, toileting, transfers, walking and mobility.

The negotiated service agreement and service plan dated 03/24/2020 directed staff the resident required assistance with all aspects of bathing, dressing, and toileting due to cognitive deficits. She required assistance of one to two people depending on cognitive level and ability to stand. A mechanical lift may be used if necessary. She utilized a wheelchair for mobility and was unable to wheel herself.

Observation on 11/05/2020 at 9:33 AM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3245	Continued From page 25	S3245		

direct care staff C assisted the resident with walking. The resident had a gait belt around her waist and staff C held onto the gait belt. The resident walked with a front wheeled walker to her recliner. The resident required frequent cueing and staff C assisted to maneuver the walker. Once the resident got to the recliner she attempted to sit before she was fully turned and in position. Direct care staff C needed to use most of her body and strength to move the resident over to safely sit on the recliner.

Interview on 11/05/2020 at 9:33 AM with direct care staff C indicated the resident normally needed only 1-person assistance unless she was having a bad day. When asked to define the times needing 2 staff assistance she said usually in the mornings and about twice a week. She reported she worked on the night shift before and the resident usual slept all night but if there was an emergency it would be more difficult to get her up and would need 2 people to transfer. She did not believe she could get all the residents out by herself in a timely manner of about 10 minutes.

Interview with licensed nurse E on 11/05/2020 confirmed she did not identify this resident on the resident roster as needing a two person assist with transfers but indicated the resident did at times need a two-person transfer.

- Record review for resident #289 revealed an admission date of 08/29/2018.

The annual functional capacity screen dated 08/26/2020 indicated the resident needed physical assistance with bathing dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3245	Continued From page 26	S3245		

toileting and transfers and had deficits in all aspects of cognition.

The negotiated service agreement dated 08/26/2020 included services to be provided by facility staff of bathing, dressing, toileting, incontinence management, transfers and mobility.

The health Service plan dated 08/26/2020 directed staff to provide the entire task for bathing, dressing and grooming. Staff will assist with toileting needs and changing of incontinent products. He required a one to two-person physical assist with all transfers. He could self-propel his wheelchair at times but needed assistance to get to a particular place.

Observation on 11/05/2020 at 9:45 AM revealed direct care staff A applied a gait belt around the resident's waist. She instructed the resident to put his hands on her arms and told him to stand up and to stand tall. The first attempt to get him to stand resulted in no effort on his part then he stood but his knees remained flexed and she pivoted him into the recliner.

Interview on 11/05/2020 at 9:45 AM with direct care staff A indicated the resident could on some days stand good and on other days not very good. She did not know if she could get him up by herself during the night in an emergency.

Interview on 11/03/2020 at 11:27 AM with licensed nurse E revealed she marked the resident roster for this resident as needing a one to two-person transfer because of having bad days with his ADL (activities of daily living) abilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3245	Continued From page 27	S3245		

- Record review for resident #323 revealed he had diagnoses of Parkinson's and dementia.

The resident roster provided by licensed nurse E on 11/03/2020 indicated the resident required 1 to 2 staff assistance for transfers.

The annual functional capacity screen dated 09/01/2020 identified the resident with cognitive deficits in all aspects and he needed physical assistance with bathing, dressing, toileting, transfers, walking and mobility.

The negotiated service agreement dated 09/01/2020 included services of staff assistance with bathing, dressing, toileting with incontinence care, transfers and mobility.

The health Service plan dated 09/01/2020 directed staff to assist through the entire task of bathing, grooming/hygiene, toileting. Under transfers licensed nurse E wrote for 1 staff to physical assist with a walker and may use a wheelchair on days when walking is difficult.

Observation on 11/05/2020 at 9:52 AM revealed direct care staff A applied a gait belt to the resident's waist and then retrieved the resident's walker placing it in front of the resident who sat in wheelchair in the living room. She placed the walker in front of the resident, direct care staff C came and assisted with the transfer. Direct care staff A told the resident to stand, he reached out and grabbed the walker. He stood up with the assistance of the 2 staff and was wobbly while trying to take steps and leaned sideways when taking a few steps to the recliner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3245	Continued From page 28 Interview on 11/05/2020 at 9:52 AM with direct care staff A indicated sometimes the resident transferred well and on other days he needed 2 staff. She said he only needed one staff if he stood well and took steps. She indicated when the weather changed, and it got cold he started having more trouble possibly due to arthritis. - The annual functional capacity screen dated 08/18/2020 for resident #411 identified the resident with cognitive impairment in all aspects and she required physical assistance with bathing, dressing, toileting, transfers and mobility. The negotiated service agreement dated 08/18/2020 included services of staff performance for bathing, dressing, toileting, transfers and mobility. An addendum to the negotiated service agreement dated 09/06/2020 directed a change for one to two staff assistance with transfers. The health Service plan dated 08/18/2020 directed staff to provide full assistance with bathing, dressing, and toileting. Under transfers licensed nurse E wrote the resident needed physical assistance able, was able to bear weight but needed prompting throughout the task of mobility. Staff needed to assist with all aspects of movement from bed to chair or wheelchair. Observation on 11/05/2020 at 9:42 AM revealed direct care staff A prepared to transfer the resident from a wheelchair to the couch with a gait belt applied around the resident's waist. When ready to make the transfer direct care staff	S3245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N059017	A. BUILDING: _____ B. WING _____	C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL ARMS	1318 OAKLANE MCPHERSON, KS 67460

(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
S3245	Continued From page 29 C came to assist for the transfer. The resident bore minimal weight while the two staff pivoted her to the couch. Interview on 11/05/2020 at 9:42 AM with direct care staff A & C revealed sometimes you could transfer the resident by yourself but not always. They indicated she is a lot of weight to lift by yourself if she isn't helping and if she's been sleeping or sleepy, she's harder to get to stand. Interview on 11/03/2020 at 11:27 AM with licensed nurse E revealed she marked the resident roster for this resident as needing a one to two staff assistance with transfers because of her having bad days and lack of ADL abilities. For all of the above findings the administrator/operator failed to provide sufficient staffing to ensure residents who required assistance of two staff to transfer and get to a safe place in the event of an emergency. This deficient practice had the potential to affect all residents if the 1 staff member would be tied up with a resident needing a 2 person transfer.	S3245		