STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N096011	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIA COURT	633 E MAIN ST MULVANE, KS 67110

(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 #103005 at the above named facility on 7-26-16, 7-27-16, 7-28-16, and 8-1-16.	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 identified a census of 35 residents. The sample included 3 residents. Based on record reviews, interviews, and observations for 2 (#3 and #1) of 3 residents sampled, the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of each resident and are in accordance with the Functional Capacity Screening (FCS) and the Negotiated Service Agreement (NSA). Findings included - Record review for resident #3 revealed an admit date of 4-9-14 with diagnoses cancer of esophagus, barrett's esophagus, gastro esophageal reflux disease, and pulmonary	S3155		

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

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S3155	Continued From page 1 embolism. The annual FCS dated 4-13-16 recorded resident independent with toileting, transfer, walking/mobility, eating, bladder incontinence, cognition, communication, required physical assistance with bathing, dressing, and experienced falls/unsteadiness. The annual NSA dated 4-13-16 recorded staff to assist with medications/treatments per physician orders, assist with dressing and shower two times a week. Staff to assist with keeping room free of clutter and walk areas unobstructed. Spouse and family will transport resident to and from medical appointment. The annual Health Care Service Plan (HCSP) dated 4-13-16 recorded resident independent with toileting, transfers, walking/mobility, eating, cognition, communication, and continent of bowel and bladder control. The staff to assist with showers two times a week, dressing morning/evenings, administer medications/treatments as ordered by physician. Resident has history of falls, staff and resident to keep room clean/free of clutter and walk areas unobstructed. Laboratory reports of Absolute Neutrophils (type of white blood count that fights infection) document the normal range as 1.90 to 7.00. Resident #3's Absolute Neutrophils ranged from 0.40 to 1.64 from 6-6-16 to 7-25-16. On 7-27-16 resident provided a written order from physician stating: If experiencing chills or a fever, call right away. Phone number and after hours phone number provided.	S3155		

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S3155	Continued From page 2 The HCSP lacked interventions to address increased risk of infections related to chemotherapy or signs/symptoms of infections for staff to report to the nurse. Interview on 7-27-16 at 11:30 a.m. with resident #3 stated had several chemo-therapy treatments through his/her port on right side of upper chest. He/she goes to cancer center where the chemo-therapy treatment is accessed through the port and has continuous intravenous treatment for one week from the chemo-therapy pump he/she takes with him/her. Resident further stated was told to wash hands frequently and not be around a lot of people or crowded places due to low blood counts and high risk of infections. The HCSP lacked interventions to address care of the port and monitoring of chemotherapy administered via pump through the port. Interview on 7-27-16 at 1:30 p.m. with licensed nurse A stated and confirmed the NSA/HCSP did not identify resident had a port, chemo-therapy continuous at week at a time from a pump attached to the port, identified interventions for care of port or chemo-therapy pump or address resident at high risk for infections. For resident #3, the operator/licensed nurse failed to ensure the HCSP contained interventions for high risk of infections, signs/symptoms of infections, care of port and site, interventions for care of chemo- therapy pump with continuous chemo treatment one week at a time. - Record review for resident #1 revealed an admit date of 7-7-16 with diagnoses traumatic compartment syndrome, right lower extremity	S3155		

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S3155	Continued From page 3 (RLE) lacerations with foreign body, depressive disorder, atrial fibrillation, hypertension and methicillin resistant staphylococcus arouse (MRSA). The admission FCS dated 7-7-16 recorded resident independent with eating, bladder incontinence, cognition, communication, required supervision with walking/mobility, required physical assistance with bathing, dressing, toileting, transfer, supervision with medication management, physical assist with treatments, and experienced falls/unsteadiness. Recent fall at home and hospitalized for leg wound. Daily dressing change to right lower extremity. The admission NSA dated 7-7-16 recorded staff will manage residents treatments. Home health will manage wound vac and dressing changes. Staff will assist resident with ambulation in room and wheel chair to areas other than room. Staff will assist resident with dressing, toileting, bathing due to wound vac device. The admission NSA lacked infection control for methicillin resistant staphylococcus aureus (MRSA). The admission HCSP dated 7-7-16 recorded resident required physical assist with bathing, due to weakness, showering, and to help cover leg dressing. The resident will also require physical assistance with dressing and toileting due to weakness. Assist resident with transfers and move wound vac equipment. Resident will require physical assistance with four wheeled walker for short distances in room for ambulation and use wheel chair for long distances. Family will prefill medication planner weekly. Home health will provide treatments per physician	S3155		

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S3155	Continued From page 4 orders. Resident to call staff for ambulation and transfer needs due to risk for falls. The admission HCSP lacked infection control for draining wound with MRSA. The re admission FCS dated 7-25-16 recorded resident independent with dressing, toileting, transfer walking/mobility, eating bladder incontinence cognition communication, required supervision with medications, physical assistance with shower, management of treatments, and experienced falls/unsteadiness. The readmit NSA dated 7-25-16 recorded resident self-administered medications. Family will set up medication planner weekly. Staff will assist with treatments per physician orders. Staff will assist with bathing-proper coverage of RLE wound and safely get resident in and out of shower. Daily dressing change to RLE. The re-admit HCSP dated 7-25-16 recorded resident's family will prefilled medication planner and staff will supervise. Staff will assist with treatments per physician orders, assist resident with bathing-proper coverage of RLE wound and safely assist getting in and out of shower. The HCSP lacked interventions to monitor for s/s of infection, how to cover wound for bathing, and infection control for resident, staff, other residents. The history and physical dated 6-30-16 recorded: active diagnoses, MRSA in leg wound, increased confusion, wound vac to right leg. The history and physical dated 7-5-16 revealed RLE wound measured 14 centimeters (CM) by 9 CM by 0.1 CM.	S3155		

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S3155	Continued From page 5 The hospital history and physical dated 7-22-16 and 7-25-16 recorded skin graft to RLE clean graft has 100 % take, pink, blanching, adherent with not signs/symptoms of infection including surrounding tissue. On 7-25-16 staples removed and resident sent to facility. The nurses notes recorded the following: On 7-8-16 at 10:16 p.m. Resident in bathroom and staff noticed the tubing was not clamped and resident was disconnected from the wound vac and it was turned off by resident. Staff connected tubing and turned pump on. Signed certified staff D. On 7-9-16 at 4:05 p.m. Tube on wound vac kinked at the site. . . Signed certified staff C. On 7-10-16 at 11:30 a.m. This nurse was notified that canister on wound vac was full and the bandage on right leg was draining. The opsite (permeable clear dressing) was pulled up and it was noted that resident had placed toilet paper around wound and had not notified staff that it was leaking. Continue every two hour checks on wound vac. Signed licensed staff B. On 7-11-16 at 1:30 p.m. Resident reported wound vac leaking. Area reinforced with gauze and kling wrap (stretch gauze wrap). Noted resident finger nails long and had been picking at wound dressing. Family trimmed nails. Encouraged resident to wash hands frequently as well as hand sanitizer. Signed licensed staff B. On 7-12-16 at 10:32 p.m. Went into resident room to change linens. The wound vac was turned off. Resident had the opsite pulled back and complained of itching at the site. Resident	S3155		

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S3155	Continued From page 6	S3155		

has gauze over the area to catch the drainage. Staff was not notified. Instructed resident on importance of leaving wound site intact. Continue two hour checks. Signed licensed staff E.

On 7-13-16 at 3:50 p.m. Staff went into resident room to do two hour check and resident had pulled off original bandage and changed it using masking tape. Educated resident on calling staff for assistance with dressings. Will continue to monitor. Signed licensed staff E.

On 7-13-16 at 7:15 p.m. staff alerted this nurse that wound vac was not turned on. Went into the room and found wound vac had been unplugged and turned off. It was plugged in and restarted. Educated resident the importance of notifying staff if he/she needed assistance with the wound vac. Signed licensed staff E.

On 7-20-16 at 4:36 p.m. Resident notably very noncompliant with wound vac and dressings. Resident expressed he/she did not like them and at times is uncomfortable. Resident has been noted to be disassembling dressing periodically. Encouraged resident to leave wound vac and dressings in place for proper wound healing. Resident in agreeance and discussed risks and benefits of compliance verses noncompliance with wound management. Signed operator/licensed staff.

On 7-21-16 resident to hospital for graft surgery. Signed licensed staff E.

On 7-25-16 at 2:00 p.m. Resident returned to facility. Resident in wheelchair with dressing to RLE and upper extremity from graft site. Resident educated o leaving the dressings in place and the nursing staff will do dressing

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S3155	Continued From page 7	S3155		

changes. Signed licensed staff B.

On 7-26-16 at 10:50 a.m. Dressing changed today to RLE measured 14 CM by 7 CM by .2 CM. Scant serosanguineous drainage. Resident now more independent with care since removal of wound vac. Signed operator/licensed staff.

On 7-26-16 at 2:45 p.m. observed wound site of RLE. Wound covered with permeable clear dressing. Site clean with no drainage at this time. Measurements recorded by licensed staff this a.m. record 14 CM long by 7 CM wide, by .2 CM depth. Resident stated the site felt much better and can do most activities of daily living by self.

Interview on 7-26-16 at 2:15 p.m. with certified staff F stated resident was not placed in isolation but staff wore gowns and gloves. Placed gowns/gloves in a red bag then took bag to bio-hazard room for disposal.

Interview on 7-26-16 at 2:20 p.m. with certified staff C stated a sign was posted on door that stated contact precaution and to contact nursing before entering room. The sign was removed on 7-25-16.

Interview on 7-26-16 at 2:35 p.m. with licensed staff B stated had a sign posted on the door that stated contact precaution and to notify nursing before entering the room. The gowns, masks, gloves, red bio hazard bags are in the small chest with drawers beside the front door of resident's room. Licensed staff B stated and confirmed resident was non-compliant with wound vac. and the HCSP lacked interventions for care of wound vac, wound and contact precautions for draining wound with MRSA.

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MARIA COURT	633 E MAIN ST MULVANE, KS 67110

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S3155	Continued From page 8 For resident #1, the operator failed to ensure the HCSP contained interventions for wound care, wound vac, contact precautions for wound identified with MRSA. For residents #3 and #1, the operator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that meet the needs of each resident and are in accordance with the FCS and the NSA.	S3155		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(c) The facility identified a census of 35 residents. The sample included 3 residents. Based or record review and interview for 2 (#1 and #3) of 3residents sampled, the licensed nurse failed to appropriately delegate nursing procedures (as outlined under the Kansas nurse practice act) to certified medication aides related to performing wound care, and care of resident with a port for intravenous chemotherapy and at risk for infection secondary to low white blood count. The licensed nurse failed to ensure documentation	S3166		

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MARIA COURT	633 E MAIN ST MULVANE, KS 67110

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S3166	Continued From page 9	S3166		

related to the delegation of nursing task was included in the resident's plan of care and in the personnel files of each designated medication aide.

Findings included:

- Record review for resident #1 revealed an admit date of 7-7-16 with diagnoses traumatic compartment syndrome, right lower extremity (RLE) lacerations with foreign body, depressive disorder, atrial fibrillation, hypertension and methicillin resistant staphylococcus arouse (MRSA).

The admission FCS dated 7-7-16 recorded resident independent with eating, bladder incontinence, cognition, communication, required supervision with walking/mobility, required physical assistance with bathing, dressing, toileting, transfer, supervision with medication management, physical assist with treatments, and experienced falls/unsteadiness. Recent fall at home and hospitalized for leg wound. Daily dressing change to right lower extremity.

The admission NSA dated 7-7-16 recorded staff will manage residents treatments. Home health will manage wound vac and dressing changes. Staff will assist resident with ambulation in room and wheel chair to areas other than room. Staff will assist resident with dressing, toileting, bathing due to wound vac device.

The admission NSA lacked infection control for methicillin resistant staphylococcus aureus (MRSA).

The admission HCSP dated 7-7-16 recorded resident required physical assist with bathing, due

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S3166	Continued From page 10	S3166		

to weakness, showering, and to help cover leg dressing. The resident will also require physical assistance with dressing and toileting due to weakness. Assist resident with transfers and move wound vac equipment. Resident will require physical assistance with four wheeled walker for short distances in room for ambulation and use wheel chair for long distances. Family will prefill medication planner weekly. Home health will provide treatments per physician orders. Resident to call staff for ambulation and transfer needs due to risk for falls.

The re admission FCS dated 7-25-16 recorded resident independent with dressing, toileting, transfer walking/mobility, eating bladder incontinence cognition communication, required supervision with medications, physical assistance with shower, management of treatments, and experienced falls/unsteadiness.

The readmit NSA dated 7-25-16 recorded resident self-administered medications. Family will set up medication planner weekly. Staff will assist with treatments per physician orders. Staff will assist with bathing-proper coverage of RLE wound and safely get resident in and out of shower. Daily dressing change to RLE.

The re-admit HCSP dated 7-25-16 recorded resident's family will prefilled medication planner and staff will supervise. Staff will assist with treatments per physician orders, assist resident with bathing-proper coverage of RLE wound and safely assist getting in and out of shower.

The history and physical dated 6-30-16 recorded: active diagnoses, MRSA in leg wound, increased confusion, wound vac to right leg.

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S3166	Continued From page 11 The hospital history and physical dated 7-22-16 and 7-25-16 recorded skin graft to RLE clean graft has 100 % take, pink, blanching, adherent with not signs/symptoms of infection including surrounding tissue. On 7-25-16 staples removed and resident sent to facility. The nurses notes recorded the following: On 7-8-16 at 10:16 p.m. Resident in bathroom and staff noticed the tubing was not clamped and resident was disconnected from the wound vac and it was turned off by resident. Staff connected tubing and turned pump on. Signed certified staff D. On 7-9-16 at 4:05 p.m. Tube on wound vac kinked at the site, replaced the wrap. Signed certified staff C. Nurses noted 07-10-16 through 7-20-16 documented numerous issues with wound vac and dressings related to leaking, resident turning off wound vac and picking at dressing and area. On 7-20-16 at 4:36 p.m. Resident notably very noncompliant with wound vac and dressings. Resident expressed he/she did not like them and at times is uncomfortable. Resident has been noted to be disassembling dressing periodically. Encouraged resident to leave wound vac and dressings in place for proper wound healing. Resident in agreeance and discussed risks and benefits of compliance verses noncompliance with wound management. Signed operator/licensed staff. On 7-21-16 resident to hospital for graft surgery. Signed licensed staff E.	S3166		

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S3166	Continued From page 12 On 7-25-16 at 2:00 p.m. Resident returned to facility. Resident in wheelchair with dressing to RLE and upper extremity from graft site. Resident educated to leaving the dressings in place and the nursing staff will do dressing changes. Signed licensed staff B. Interview on 7-26-16 at 2:35 p.m. with licensed staff B and confirmed resident was non-compliant with wound vac , the HCSP lacked interventions for care of wound vac, wound and contact precautions for draining wound with MRSA and confirmed wound care not delegated to certified medication aides. For resident #1, the licensed nurse failed to appropriately delegate nursing procedures to certified medication aides related to performing wound care.. - Record review for resident #3 revealed an admit date of 4-9-14 with diagnoses cancer of esophagus, barrett's esophagus, gastro esophageal reflux disease, and pulmonary embolism. The annual FCS dated 4-13-16 recorded resident independent with toileting, transfer, walking/mobility, eating, bladder incontinence, cognition, communication, required physical assistance with bathing, dressing, and experienced falls/unsteadiness. The annual NSA dated 4-13-16 recorded staff to assist with medications/treatments per physician orders, assist with dressing and shower two times a week. Staff to assist with keeping room free of clutter and walk areas unobstructed. Spouse and	S3166		

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S3166	Continued From page 13 family will transport resident to and from medical appointment. The annual Health Care Service Plan (HCSP) dated 4-13-16 recorded resident independent with toileting, transfers, walking/mobility, eating, cognition, communication, and continent of bowel and bladder control. The staff to assist with showers two times a week, dressing morning/evenings, administer medications/treatments as ordered by physician. Resident has history of falls, staff and resident to keep room clean/free of clutter and walk areas unobstructed. Laboratory reports of Absolute Neutrophils (type of white blood count that fights infection) document the normal range as 1.90 to 7.00. Resident #3's Absolute Neutrophils ranged from 0.40 to 1.64 from 6-6-16 to 7-25-16. On 7-27-16 resident provided a written order from physician stating: If experiencing chills or a fever, call right away. Phone number and after hours phone number provided. The HCSP lacked interventions to address increased risk of infections related to chemotherapy or signs/symptoms of infections staff to report to the nurse. Interview on 7-27-16 at 11:30 a.m. with resident #3 stated had several chemo-therapy treatments through his/her port on right side of upper chest. He/she goes to cancer center where the chemo-therapy treatment is accessed through the port and has continuous intravenous treatment for one week from the chemo-therapy pump he/she takes with him/her. Resident further	S3166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N096011	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIA COURT	633 E MAIN ST MULVANE, KS 67110

(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
S3166	Continued From page 14 stated was told to wash hands frequently and not be around a lot of people or crowded places due to low blood counts and high risk of infections. The HCSP lacked interventions to address care of the port and monitoring of chemotherapy administered via pump through the port. Interview on 7-27-16 at 1:30 p.m. with licensed nurse A stated and confirmed the NSA/HCSP did not identify resident had a port, chemo-therapy continuous at week at a time from a pump attached to the port, identified interventions for care of port or chemo-therapy pump or address resident at high risk for infections and did not delegate care and monitoring of port to certified staff.. For resident #3, the operator/licensed nurse failed to delegate to certified staff how to care for resident with high risk of infections, signs/symptoms of infections, care of port and site, interventions for care of chemo- therapy pump with continuous chemo treatment one week at a time.	S3166		