STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175522	A. BUILDING _____ B. WING _____	C 02/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY VILLAGE	1401 CHERRY LN GREAT BEND, KS 67530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of Complaint #83512, #81943, and #82488. A revised copy of the deficiencies was sent to the provider on 2/24/15.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The skilled facility had a census of 34 residents, and the assisted living had a census of 18. The sample included 9 residents, 6 of which were reviewed for falls. Based on observation, record review and interview, the facility failed to investigate and report to the state agency, an unwitnessed incident when staff found Resident #1 on the floor, unresponsive, and a fall with injury for Resident #3.

Findings included:

- Resident #1's annual (MDS) Minimum Data Set assessment, dated 12/19/14, indicated the resident had short and long term memory problems, moderately impaired cognition, inattention, disorganized thinking and wandering behavior. The MDS further indicated the resident ambulated independently, and had no falls since his/her prior assessment.

The 12/24/14 care plan indicated the resident ambulated independently, wandered, and needed encouragement to keep his/her oxygen on.

The 1/15/15 at 2:37 AM nurse's note stated the resident was found on the floor, in a hallway, on the special care unit, at 1:15 AM.

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F 225	Continued From page 2	F 225		

On 2/2/15 at 1:45 PM, Administrative Staff F verified the facility had not completed an investigation regarding the resident found who was found on the floor, unresponsive, and did not report the incident to the state agency.

On 2/3/15 at 8:40 AM, Nurse A verified staff alerted him/her the resident was on the floor in the special care unit. Nurse A verified when he/she entered the special care unit, the resident was in the hallway, on his/her bed.

On 2/3/15 at 9:30 AM, Nurse Aide B verified he/she found the resident lying in a hallway on the special care unit at 1:15 AM on 1/15/15. Nurse Aide B stated the resident wasn't breathing, but after he/she shook the resident by the shoulders, he/she had agonal (abnormal pattern of breathing, characterized by gasping and labored) breathing. Nurse Aide B stated prior to alerting the nurse, he/she got the resident's bed from his/her room, brought it into the hallway, and with the assistance of Nurse Aide C, transferred the resident from the floor on to the bed. Nurse Aide B stated he/she stayed with the resident while Nurse Aide A alerted the nurse.

The facility's Abuse, Neglect and Exploitation policy, dated 4/20/13, stated an injury of unknown source would be when the injury was not observed by any person, or the source of injury could not be explained by the resident. The policy stated the facility would file an investigation in the facility, and with the state agency. Upon completion of the investigation, the results would be reported to that state agency within 5 working days of the incident.

The facility failed to investigate and report to the

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state agency, Resident #1's unwitnessed, unresponsive incident.

- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 1/8/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 2, which indicated he/she had severe impaired cognition. The MDS indicated the resident required extensive assistance from staff for transfers, had upper and lower extremity impairment, had unsteady balance, did not ambulate, and used a wheelchair for mobility. The MDS indicated the resident had no falls since his/her prior assessment.

The 1/9/15 care plan directed the staff to have the resident's call light in reach, and encourage him/her to use it, and to respond promptly for requests for assistance.

The 1/22/15 at 4:30 AM nurse's note stated the staff heard the resident cry out, and found the resident face down on the floor beside his/her bed. The resident was conscious, had a large bruise and a bump with a small abrasion on the left side of his/her forehead, the area around and below his/her eye was red,with bruising, and the bridge of his/her nose was swollen and started to bruise. A skin tear was noted on his/her left elbow. The resident voiced stiffness and slight discomfort. The bruise to the left forehead measured 7.5 (cm) centimeters by 4 cm, with 1.0 cm x 1.0 cm abrasion to the middle of the bruise. The skin tear to his/her left elbow was "C" shaped, and measured 1 cm in width.

On 2/2/15 at 3:51 PM, observation revealed the resident, seated in his/her recliner. Further observation revealed the resident's entire face

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had bruises, and a scabbed area to the left side of his/her forehead.

On 2/3/15 at 10:49 AM, Nurse G verified the resident rolled out of bed, and hit his/her head and staff performed neurological checks on the resident.

On 2/4/15 at 9:30 AM, Administrative Nurse E verified the resident fell on 1/22/15, and received injuries to his/her face and elbow. Administrative Nurse E verified the facility did not report the fall to the state agency.

The facility's undated fall protocol stated should a fall occur, the staff should assess the type of fall, take vital signs in the position of the fall and standing, every shift for 72 hours post fall, and record the vital signs in the the medical record. If there is any injury, the staff should chart in the progress noted at 24, 48 and 72 hours, and weekly there after until the injury is resolved.

The facility's Abuse, Neglect and Exploitation policy, dated 4/20/13, stated an injury of unknown source would be when the injury was not observed by any person, or the source of injury could not be explained by the resident. The policy stated the facility would file an investigation in the facility, and with the state agency. Upon completion of the investigation, the results would be reported to that state agency within 5 working days of the incident.

The facility failed to investigate and report to the state agency, an unwitnessed fall which resulted in injury, for Resident #3, who was found on the floor.