STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. A revised 2567 was electronically sent to the facility on 12-24-13.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents with 23 included in the sample. Based on observation and interview, the facility failed to provide dignified care for 4 residents by the failure of staff to knock and receive permission to enter resident rooms, request permission to provide a treatment, and refrain from using a cell phone while feeding a resident. (#41, 39, 20, and a resident requiring assistance with eating in house 3.) Findings included: - Observation on 12/10/13 from approximately 3:30-3:45 p.m., during an interview with resident #41, multiple staff members entered the resident's room without knocking or announcing themselves. Observation on 12/12/13 at 10:57 a.m. revealed a	F 241		

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
	175514	A. BUILDING _____ B. WING _____	12/19/2013

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F 241	Continued From page 1	F 241		

housekeeper entered the resident's room without knocking and removed a wet floor sign.

Observation on 12/12/13 at 2:48 p.m. revealed as this surveyor interviewed the resident's family member, licensed nursing staff UU entered the resident's room without knocking or announcing him/herself.

Observation on 12/16/13 at 6:25 a.m. revealed direct care staff VV went into the resident's room and did not knock or announce him/herself.

Observation on 12/16/13 at 7:05 a.m. revealed licensed nursing staff KK went into the resident's room without knocking. At 7:07 a.m., observation revealed staff KK sat on the resident's bed and attempted to take the dressing off of the resident's right leg as the resident sat in his/her wheelchair. The resident's head was down and his/her eyes were closed. As the resident started to rouse, staff KK asked the resident if he/she was awake and continued to try and take the dressing off of the resident's leg. The resident woke up and said, "What is this? I was laying in bed and now I am out of my bed sitting here with some man touching my legs. Leave. I want you to leave. I was sleeping." Staff KK apologized and left the room, explaining he/she would try back later.

Interview with direct care staff LL on 12/16/13 at 1:52 p.m. revealed staff were expected to knock on resident's door before entering.

Interview with direct care staff T on 12/16/13 at 3:15 p.m. revealed when he/she went into a resident room, he/she knocked and announced that he/she was nursing staff and told the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

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DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 241	Continued From page 2	F 241		

what he/she needed to do. Staff T reported that was what was expected of staff.

Interview with licensed nursing staff KK on 12/16/13 at 4:53 p.m. revealed he/she expected staff to knock, introduce themselves, and tell the resident why they are there.

Interview on 12/17/13 at 10:49 a.m. with licensed nursing staff W revealed if a resident was sleeping, staff asked the resident if they could do the treatment then or if the resident wanted them to wait. Staff W reported staff should not do a dressing change if the resident was asleep and staff could always go back later.

Interview on 12/17/13 at 1:01 p.m. with administrative nursing staff A revealed he/she expected staff to knock and announce themselves when entering the resident rooms. Staff A reported he/she would also expect staff to wake a resident up to provide a treatment to tell them what they were doing or go back at a later time.

Review of the undated facility policy for Shower/Tub Bath revealed staff were expected to, "Knock before entering the room. 4. Identify yourself and ask the resident's permission to perform the procedure. 5. Explain the procedure."

The staff failed to provide dignified care through the failure to explain a treatment procedure to the resident and knock and receive permission before entering a resident room.

- Observation on 12/11/13 at 9:20 a.m. revealed licensed nursing staff KK came into the resident #20's room without knocking or announcing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 3	F 241		

themself.

Interview with direct care staff LL on 12/16/13 at 1:52 p.m. revealed staff were expected to knock on a resident's door before entering.

Interview with direct care staff T on 12/16/13 at 3:15 p.m. revealed when he/she went into a resident room, he/she knocked and announced that he/she was nursing staff and told the resident what he/she needed to do. Staff T reported that was what was expected of staff.

Interview with licensed nursing staff KK on 12/16/13 at 4:53 p.m. revealed he/she expected staff to knock, introduce themselves, and tell the resident why they were there.

Interview on 12/17/13 at 1:01 p.m. with administrative nursing staff A revealed he/she expected staff to knock and announce themselves when entering the resident rooms.

Review of the undated facility policy for Shower/Tub Bath revealed staff were expected to, "Knock before entering the room. 4. Identify yourself and ask the resident's permission to perform the procedure. 5. Explain the procedure."

The staff failed to provide dignified care through the failure to knock and receive permission before entering a resident room.

- On 12/10/13 at 12:25 p.m. direct care staff B sat and fed a resident with the arm rest of his/her chair under the table. Staff B had his/her cell phone sitting on the arm rest of the chair and looked down at his/her phone pushing buttons instead of feeding the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 241	Continued From page 4 Staff failed to provide dignified care through a failure to provide a dependent resident attention during a meal. - On 12/16/13 at 7:18 a.m.,direct care staff B entered the room of resident #39 to assist the resident up out of bed for the day. At 7:22 a.m., direct care staff I entered the room without knocking. Once staff I saw the surveyor, staff I stopped and said "Oops!" and smiled, then continued on into the room. Staff failed to provide dignified care through a failure to knock and receive permission before entering a resident's room.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility census included 72 residents with 23 in the sample. Based on observation, interview, and record review the facility failed to provide medically-related social services for 1 of 3 residents reviewed for dental services. (#41) Findings included: - Review of resident #41's signed physician	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 250	Continued From page 5	F 250		

orders dated 11/4/13 revealed the resident had a diagnosis of malnutrition. The resident admitted on 3/29/12.

Review of the annual MDS (minimum data set) dated 4/6/13 revealed a BIMS (brief interview for mental status) score of 14, indicating no cognitive impairment. The resident required limited assistance of one staff for transfers, supervision with setup assistance for eating, and extensive assistance of one staff for locomotion on and off the unit. The resident had not had any significant weight loss. The resident had no natural teeth or tooth fragments, but did not have any difficulty chewing.

Review of the quarterly MDS dated 10/7/13 revealed a BIMS score of 14, indicating no cognitive impairment. The resident required supervision with setup assistance for transfers and eating, the resident did not walk, and required extensive assistance of one staff for locomotion on and off the unit. The resident did not have any significant weight loss. The resident did not have any dental concerns, including difficulty chewing. The resident had participated in care planning.

Review of the Dental CAA (care area assessment) dated 4/17/13 revealed the resident did not have any natural teeth, did not wear dentures, and saw the dentist and had no concerns at that time. Staff completed an oral assessment on 4/16/2013. The resident had not complained of pain and there resident had no abnormal tissue in his/her mouth area.

Review of the resident's care plan last reviewed 10/20/13, revealed interventions directed staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 250	Continued From page 6	F 250		

help remind the resident to brush his/her gums as he/she did not have any teeth.

Review of an admission assessment dated 3/29/12 revealed the resident did not have any teeth or dentures.

Review an interdisciplinary note dated 3/21/13 revealed the resident's DPOA (durable power of attorney) had refused to enroll the resident into the RESI-DENT (a program for dental services) program stating that the resident would not wear dentures and he/she could not afford it. The resident's DPOA stated he/she would be looking elsewhere for more affordable dental services. The social services staff suggested the resident's DPOA set up an appointment at another income-based medical facility that provided dental services. There were no further notes indicating follow-up by the staff.

Review of a Consent to Dental Examination revealed on 3/22/13 the resident had consented to an oral screening examination for the RESI-DENT program.

Review of a Malnutrition Risk Assessment dated 4/8/13 revealed a score of 8, with a score of greater than 10 indicating high risk. For the Oral Health Status portion of the assessment revealed a score of 0 with the scale listed as: 0-teeth/dentures in good condition, 1-lost dentures or several missing teeth, 2-edentulous (no teeth), 3-difficulty swallowing/frequent choking. For the section for self-feeding ability, a score was marked 2 with the scale listed as: 0-feeds self, 1-feeds self with verbal cues, 2-feeds self slowly and only part of a meal, 3-fed by staff or tube feed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 250	Continued From page 7	F 250		

Review of a Malnutrition Risk Assessment dated 10/8/13 revealed a score of 4, with a score of greater than 10 indicating high risk. For the Oral Health Status portion of the assessment revealed a score of 0 with the scale listed as: 0-teeth/dentures in good condition, 1-lost dentures or several missing teeth, 2-edentulous, 3-difficulty swallowing/frequent choking. For the section for self-feeding ability, a score was marked 0 with the scale listed as: 0-feeds self, 1-feeds self with verbal cues, 2-feeds self slowly and only part of a meal, 3-fed by staff or tube feed.

Review of a Therapy to Nursing Communication dated 12/3/13 revealed the resident had requested extra time to eat at meals.

Review of the December 2013 Meal Intake Record (through 12/16/13) revealed the resident ate 100% on 5 meals, 80% for 12 meals, 70% for 3 meals, 60% for 9 meals, 50% for 3 meals, 40% for 10 meals, did not eat 2 meals, and was out of the facility for 5 meals.

Observation on 12/12/13 at 12:23 p.m. revealed the resident sat at the dining table and was served a regular consistency turkey potpie, cooked spinach, spiced pears, a dinner roll, and a small can of diet lemon lime soda. The resident ate a few bites of each item and drank all of the soda. The resident did not have teeth.

Observation on 12/16/13 at 7:49 a.m. revealed the resident sat in his/her wheelchair at the sink and provided his/her own oral care by brushing his/her gums.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 250	Continued From page 8	F 250		

Observation on 12/16/13 at 8:19 a.m. revealed the staff served the resident hot tea, V-8 juice, a pancake, sausage patty, slice of bacon, and a fried egg over easy. The resident ate a few bites of each item. The resident did not have teeth.

Interview with the resident's family member on 12/12/13 at 3:00 p.m. revealed the resident needed dentures because the resident struggled to chew sometimes, but the resident nor the family could afford them. The family member reported he/she thought dentures cost around $2000 and stated, "I hate to see [gender] struggle, but we cannot afford to get [gender] dentures." The family member reported the resident had just learned to take his/her time and take small bites.

Interview with the resident on 12/17/13 at 1:43 p.m. revealed he/she would wear dentures if he/she had them. The resident reported he/she wanted dentures "so, so badly," and needed someone to help him/her get some.

Interview with direct care staff LL on 12/16/13 at 1:52 p.m. revealed the resident did not have dentures but had lots of missing teeth.

Interview with direct care staff T on 12/16/13 at 3:15 p.m. revealed the resident did not have dentures and ate without any chewing trouble, but frequently fell asleep while eating.

Interview on 12/17/13 at 2:30 p.m. with social services staff Z revealed the resident wanted to be a part of the RESI-DENT program, but it required the resident pay $60 per month. Staff Z reported talking to the resident's DPOA about the program because the DPOA knew about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 250	Continued From page 9	F 250		

resident's finances. Staff Z reported the resident's DPOA said the resident could not afford the program because then the resident would only have $2 a month left after all his/her bills were paid. Staff Z reported the DPOA also said the resident would not remember to wear dentures even if he/she had them and would not like them. Staff Z reported he/she knew the resident wanted dentures because he/she would see the resident in the dining room and the resident would say, "I want some teeth, I want some teeth." Staff Z reported he/she spoke with the resident's DPOA about setting up an initial appointment at the other income based dental provider, but the DPOA would not do it. Staff Z reported he/she could not make the appointment because the initial appointment had to be done by family because they know about the resident's finances. Staff Z reported there really was not a whole lot he/she could do without the cooperation of the DPOA because of the financial issue. Staff Z confirmed he/she had not documented any further conversations with the resident's family regarding dentures.

Interview with licensed nursing staff KK on 12/16/13 at 4:53 p.m. revealed the resident did not have teeth but ate okay.

Interview on 12/17/13 at 10:49 a.m. with licensed nursing staff W revealed he/she thought the resident saw a dentist. Staff W reported if a resident had a dental concern, staff talked to the resident about preferences for a dentist, then talked with the resident's physician, and scheduled an appointment. Staff W reported social services helped some with getting dental appointments arranged.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 250	Continued From page 10 Interview with administrative nursing staff A on 12/17/13 at 1:01 p.m. revealed the resident and his/her family did not want dentures. Staff A reported the facility staff had multiple discussions with the resident's family about dental care and had offered to get him/her services and they had refused. Staff A reported the social worker probably had pages and pages documented on the resident/family conversations about the dental issues. Review of the undated facility policy for Dental Services revealed, "Facility staff will, if requested or needed, assist residents in arranging for dental services." The facility failed to provide medically-related social services to assist a resident with getting dentures.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents. Based on observation and interview the facility failed to provide housekeeping and maintenance services to distinguish personal toiletries, including tooth brushes, and washcloths for residents in semi-private rooms to ensure each resident had sanitary, orderly conditions. This had the potential to affect 20 residents.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 253	Continued From page 11	F 253		

Findings included:

- On 12-16-13 at 9:18 a.m. resident #19 stated that he/she did not know what washcloth to use of the 2 that were on the vanity. The resident stated he/she did not like using a washcloth that someone else had used and did not like staff using his/her tooth brush for the roommate. The resident stated he/she had purchased new toothbrushes because staff used his/hers on the other resident.

On 12-16-13 an observation of a semiprivate room that was occupied by 2 residents revealed 2 used washcloths on the vanity by the sink and 1 hand towel on the rail by the toilet. A container by the sink had a toothbrush and other personal items in it that were not labeled with a resident name or bed number. The medicine cabinet contained multiple personal items and only 1 item had a name on it.

On 12-16-13 an observation of a semiprivate room occupied by 2 residents had only 1 towel bar, 3 toothbrushes and none of them were marked.

On 12-16-13 an observation of a semiprivate room occupied by 2 residents revealed 1 towel bar with 1 hand towel hanging in it. On the right side of the vanity there were the following personal items that were not labeled, shampoo, hairspray, lotion, hair care items, green tooth brush and tooth paste in a gray basin, mouthwash, and shower gel. None of the items were labeled to identify who they belonged to. On the left side was a water mug, multiple lotions and face cream with 1 of those items labeled. There was also a soiled bed pan that was partially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 253	Continued From page 12	F 253		

covered by a plastic bag hanging on the hand rail between the sink and the toilet that was not labeled. The shower had 2 different kinds of shampoo, 5 bottles of body wash, and a bottle of conditioner and none of the items were marked.

On 12-16-13 an observation of another private room revealed 1 towel rack, multiple personal items on the left side of sink in a pink bag-not labeled. There was also denture tables and cup not marked. On the other side of the sink there were lotions, body wash, tooth brush, nail polish remover, body spray, and other items not labeled to identify who they belonged to.

On 12-16-13 at 3:52 p.m. licensed nursing staff HH stated residents did not generally keep washcloths in their rooms. Stated if they wanted one they could ask staff for one. He/she stated that everything on the bathroom cabinet belonged to one resident because the other resident was dependent and his/her belongings were in the bedside drawer. Staff HH stated he/she understood that if both residents were independent they would not know what washcloth to use and possibly what personal items since they were not labeled.

On 12-16-13 at 3:59 p.m. licensed nursing staff II observed a semiprivate room with 2 used washcloths on the cabinet. There were also a few personal items on the vanity that were not labeled. When asked how a resident would know what washcloth to use he/she stated "good question".

On 12-16-13 at 3:22 p.m. housekeeping staff AA stated he/she did not realize each resident needed to have their own towel rack that needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 253	Continued From page 13 to be labeled. The facility failed to distinguish personal toiletries and washcloths, for residents in semi-private rooms to ensure each resident had sanitary, orderly conditions. .	F 253		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents that lived in 4 houses. Based on observation and interview the facility failed to ensure sound levels did not interfere with resident's ability to participate in social interaction for residents who ate breakfast in 3 of the 4 dining rooms. Findings included: - Observation on 12-16-13 at 7:22 a.m. in the 200 house housekeeping staff turned on the vacuum sweeper, vacuumed the entryway into the house and there were 5 residents sitting at the tables. At 7:34 a.m. housekeeping staff then vacuumed around the nurses ' station. Staff then came into the TV area/dining area and noted some of the resident were talking and had to raise their voices to continue their conversation. There was one resident who looked around a couple of times while housekeeping staff vacuumed but did not say anything.	F 258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 258	Continued From page 14 On 12-16-13 at 7:49 a.m. a housekeeper vacuuming in the house 100 during the breakfast meal, staff vacuumed behind the nurses ' desk, and around the sides which were in the common area and close to the dining area. One resident looked up from and meal turned his/her head to look towards the housekeeper then continued eating breakfast. . The housekeeper continued to vacuum in the entry way and down the side in the dining area. Another staff member assisting a resident to eat turned his/her head toward the noise which was loud. On 12-11-2013 at 1:55 p.m. resident # 80 who lived in house 400, reported that housekeeping vacuumed during breakfast and it was too loud. On 12-16-13 at 8:58 a.m. resident #200 who lived in house 100, reported the vacuum was very loud and should be done before the meal or after the meal, not during the meal. He she stated the staff vacuum every morning during the meal. Interview on 12-17-13 at 12:42 p.m. revealed housekeeping/maintenance staff AA reported staff should not be using any type of equipment during the meals including the vacuum. The facility failed to maintenance a comfortable sound level for residents to socialize with each other during the meals without them having to raise their voices to hear each other.	F 258		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 279	Continued From page 15	F 279		

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility census totaled 72 residents with 23 in the sample. The sample included the review of the comprehensive care plans for 22 residents. Based on observation, interview, and record review, the facility failed to develop specific, individualized care plans for 9 of 22 sampled residents involving dental hygiene, specific targeted behaviors, indwelling Foley catheters, choices regarding sleeping arrangements and monitoring of the shunt site for a dialysis patient. (#189, #39, #19, #33, #119, #50, #193, #41 and #40).

Findings included:

- Review of resident #189's physician's review of orders, dated 11/14/13, identified the resident with the diagnosis of weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 16	F 279		

Review of the admission MDS (Minimum Data Set-a required assessment) dated 11/20/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 9/15, indicating moderately impaired cognition, no indication of depression, did not exhibit behaviors (including rejecting care), required extensive assistance of two staff for bed mobility, transfers, toileting, dependent on one staff for mobility on/off the unit, personal hygiene, and with obvious, broken, or cavities in the teeth,

Review of the Dental CAA (Care Area Assessment) dated 11/25/13 revealed the resident was at risk for altered nutritional intake related to having his/her own teeth with some missing and some that were in poor condition. He/she denied any pain or difficulty chewing although he/she was on a mechanical soft diet right now. Staff assist with his/her oral/dental care. To decrease the resident's risk for altered nutritional intake from having missing teeth and teeth in bad condition, the CAA identified the staff would be directed to provide dental care.

Review of the resident's care plan for ADL Functional/Rehabilitation Potential dated 11/25/13 revealed the resident's ability to perform independent ADLs (Activities of Daily Living) had deteriorated related to weakness from hospitalization for decubitus ulcers, cellulitis, severe protein calorie malnutrition, and personal neglect. The care plan directed staff to not rush the resident, allow extra times to complete ADLs, the resident had his/her own teeth and they were in poor condition, assist with dental/oral hygiene.

On 12/16/13 at 7:13 a.m., observation revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 17	F 279		

that direct care staff B, pushed the resident in the wheelchair to the bathroom and assisted the resident with washing his/her face, combed his/her hair for him, and put toothpaste on his/her toothbrush. The resident had a physical deformity of both hands/arms and due to the deformity, staff B attempted to place the toothbrush in one hand or the other, but the resident kept saying "No". Finally, staff B stated "here let me do that for you" and brushed the resident's teeth for him/her. Once done, staff B pushed the resident out to the dining room for breakfast.

On 12/17/13 at 10:39 a.m., Therapist J stated that the resident was born with the deformity in the hands and arms, and that prior to the hospitalization and coming to the facility, he/she lived at home with family and was independent. Therapist J stated because the resident had developed adaption techniques, he/she did better holding a regular toothbrush than an adapted one, like one with a built up handle. Therapist J identified the resident held the toothbrush with both hands to brush his/her teeth.

On 12/17/13 at 12:30 p.m., Administrative Nurses O and P, responsible for the development of the care plans, agreed they did not include the resident's adaptive ability to brush his/her teeth by holding the toothbrush with both hands, and said this would be good information to include in the care plan, especially for those who were not familiar with taking care of the resident or were new to the facility.

Review of the facility's undated Comprehensive Care Plan policy revealed the following: It is the policy of the facility to develop a comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 279	Continued From page 18	F 279		

care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ...3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident.

The facility failed to develop and implement an individualized care plan that described the unique manner in which a resident with a physical deformity brushed his/her teeth, so the staff could encourage the resident to return to independent status.

- Review of resident #39's admission record, dated 9/19/13, identified the resident had diagnosis of dementia with behavior disturbances (a progressive mental disorder characterized by failing memory, confusion, with accompanying behaviors).

Review of the significant change MDS (Minimum Data Set-a required assessment) dated 6/1/13, revealed the resident had short and long-term memory problems, severely impaired cognition, no behaviors (including rejection of care), dependent on one staff for personal hygiene, and with obvious or likely cavities or broken teeth.

Review of the dental CAA dated 6/11/13 revealed the resident needed one person assistance with oral care, and identified staff planned to monitor the resident's oral cavity for any abnormal mouth tissue.

Review of the dental care plan, dated 12/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 19	F 279		

and updated on 12/10/13 identified that the resident had broken, loose, or carious teeth related to the natural aging process and directed staff to provide one staff member for assistance for oral hygiene care and staff may consult dentist as needed.

Review of a quarterly dental assessment dated 12/9/13 identified the resident as alert, nonverbal, and unable to follow commands secondary to disease process. Immediate recent and past mental status impaired. It identified the resident had natural broken teeth but staff were unable to fully assess the resident's oral status due to current mental status.

Observation on 12/12/13 at 10:17 a.m. revealed the resident lay in bed on his/her back. Observation of the resident's bathroom revealed an unmarked electric toothbrush in a stand, as well as 2 unmarked toothbrushes located in a holder. The resident shared a room with his/her spouse. None of the toothbrushes appeared wet, or recently used. There was also a half-used rolled up tube of toothpaste on the sink as well as a half-full bottle of mouth rinse with a child-proof cap.

On 12/16/13 at 10:35 a.m., the resident's spouse, who shared the same room with the resident, stated that there were 2 regular toothbrushes and one electric toothbrush in the bathroom for use. When asked which one belonged to the resident since none of them were marked, the spouse laughed and said "I really don't know, they have gotten all mixed up."

On 12/16/13 at 4:52 p.m., direct care staff Q described the resident as dependent on staff for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 20	F 279		

all ADLs (Activities of Daily Living), including brushing the teeth, and staff are to brush his/her teeth every night. When asked which toothbrush the staff used on the resident, the electric or the manual, staff Q stated he/she did not know.

On 12/17/13 at 12:30 p.m., Administrative Nurses O and P, responsible for the development of the care plans, agreed they did not include the resident's type of toothbrush in the resident's care plan or how often to brush the resident's teeth. Both agreed that information would be beneficial for the staff that were not familiar with how to care for the resident or for those staff that were new to the facility.

Review of the facility's undated Comprehensive Care Plan policy revealed the following: It is the policy of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ...3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident.

The facility failed to develop an individualized care plan regarding dental care for a dependent resident.

- Review of resident #19's review of physician orders, signed by the physician as 12/13, identified the resident with the diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 21	F 279		

Review of the significant change MDS (Minimum Data Set-a required assessment) dated 10/30/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 4/15 (indicating severely impaired cognition), rejected care 1-3 days of the 7 day assessment, and received 7 days of antipsychotic, antidepressant, and antianxiety medications in the 7 day look back period.

Review of the Psychotropic Medication CAA (Care Area Assessment-a further assessment) dated 11/13/13, revealed the resident received Cymbalta (an antidepressant) for depression and Valium (an anti-anxiety) for anxiety, was recently started on Risperdal (an anti-psychotic) for psychosis with delusions. Pharmacy consult reviews medications monthly for GDR (Gradual Dose Reduction) if appropriate.

Review of the Psychotropic Medication Care plan, dated 11/15/13, revealed the following:
Cymbalta for depressive symptoms: Black box warning for clinical worsening and suicide risk: Monitor blood pressure WORSENING OF DEPRESSION AND/OR SUICIDAL BEHAVIOR OR THINKING. It then included a long list of potential side effects.
Diazepam (generic form of Valium) for anxiety disorder: Monitor blood pressure, and included a long list of potential side effects.
Divalproex Sodium for mood stabilization. Black box warning for hepatotoxicity (liver toxicity) and pancreatitis (inflammation of the pancreas). It then included a long list of potential side effects.
Risperidone for schizophrenia/behavioral symptoms associated with dementia in elderly: Black box warning for increased mortality in elderly patients with dementia related psychosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 22	F 279		

It then identified a long list of potential side effects.
Zolpidem, for sleep enhancement: Monitor "next-day" impairment & drowsiness, as well as a long list of potential side effects.
The care plan lacked specific, targeted behaviors for staff to monitor to ensure the medications' effectiveness.

Observation on 12/12/13 at 11:13 a.m. revealed that Licensed nurse H and direct care staff G took a mechanical lift into the resident's room to assist the resident up from the bed and into the wheelchair. The resident communicated with the staff in a pleasant manner, and did not exhibit behaviors, but was cooperative with staff.

On 12/17/13 at 12:30 p.m., administrative nurse O and administrative nurse P identified they were responsible for developing the care plans. Staff P stated they do not identify specific targeted behaviors for the residents on antipsychotic medications, or put specific targeted behaviors on the care plan so staff know what to monitor for.

Review of the facility's undated Comprehensive Care Plan policy revealed the following: It is the policy of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ...3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident.

The facility failed to care plan for specific,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 279	Continued From page 23	F 279		

targeted behaviors for each psychoactive medication for a resident.

- Review of resident #33's review of physician's orders, signed on 11/15/13, identified the resident with the diagnosis of weakness.

Review of the Annual MDS (Minimum Data Set-a required assessment), dated 4/11/13, identified the resident with short and long-term memory problems, severely impaired cognition, dependent on one staff for bed mobility, personal hygiene, dependent on two staff for transfers, toileting, and with an indwelling urinary catheter.

Review of the quarterly MDS dated 10/12/13 identified the resident with short and long-term memory problems, severely impaired cognition, dependent on one staff for bed mobility, personal hygiene, dependent on two staff for transfers, toileting, and with an indwelling urinary catheter.

Review of the Urinary Incontinence/Indwelling Catheter CAA (Care Area Assessment-a further assessment) dated 4/25/13, identified the resident had an indwelling urinary catheter due to an incompetent urethra and neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

Review of the care plan for indwelling urinary catheter, dated 1/18/11 and reviewed on 1/18/12, revealed the resident required an indwelling urinary catheter related to an incompetent urethra and neurogenic bladder. The care plan directed staff to assess drainage, record the amount/type/color/odor; observe for leakage, avoid lying the resident on top of the tubing, change catheter bag every month, change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 24	F 279		

catheter per doctor's order, do not allow tubing or any part of the drainage system to touch the floor. Keep catheter system a closed system as much as possible, position bag below level of bladder, provide one assistance for catheter care, report UTI (Urinary Tract Infection--acute confusion, urgency, frequency, bladder spasms, nocturia (urinating at night), burning, pain, difficulty urinating, low back/flank pain, malaise (weakness), nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine), use a catheter strap, and assure enough slack is left in the catheter between the meatus and strap.

On 12/17/13 at 8:50 a.m., direct care staff L and direct care staff M, together with a mechanical lift, transferred the resident from a wheelchair into bed. Once there, staff M left the room and staff L finished the care. Staff L checked the resident's incontinent brief and identified the resident's indwelling urinary catheter was leaking, and that happened at times. Staff L stated that when the resident's catheter leaked, he/she would tell the nurse and the nurse would come in and reposition the catheter. Staff L then removed the wet brief, provided perineal and catheter care, then applied a moisture barrier and a clean brief.

On 12/17/13 at 9:03 a.m., Licensed nurse GG stated that at times the resident's catheter would leak, and when that happened, they tried to reposition the catheter a little to see if it would help. If that did not work, then they would call the doctor for further directions.

On 12/17/13 at 12:30 p.m., administrative nurse O and administrative nurse P identified they were responsible for developing the care plans. Neither nurse stated they were aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 25	F 279		

staff's use of repositioning the catheter when it leaked, so that was why it was not included in the care plan.

Review of the facility's undated Comprehensive Care Plan policy revealed the following: It is the policy of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ...3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident.

The facility failed to develop an individualized care plan for a resident with an indwelling urinary catheter that had intermittent leaking issues.

- Review of resident #119's physician's review of orders, signed on 12/16/13, revealed the resident had diagnoses of wound care and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk).

Review of the admission MDS (Minimum Data Set-a required assessment) dated 11/5/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15, indicating the resident had little to no cognitive impairment, no behaviors (including refusing care), required the extensive assistance from two staff with transfers, bed mobility, toileting, required extensive assistance from one staff for personal hygiene, and identified the resident had an indwelling urinary catheter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 26	F 279		

Review of the Urinary Incontinence/Indwelling Catheter CAA (Care Area Assessment-a further assessment) dated 11/6/13, revealed the resident had a Foley catheter due to paraplegia and needed one person assistance for personal care.

Review of the indwelling urinary catheter care plan, dated 11/18/13 revealed the resident required an indwelling urinary catheter related to chronic urinary retention due to paraplegia. The care plan directed staff to avoid obstructions in the drainage system, change catheter per doctor's order, keep catheter system a closed system as much as possible, position bag below level of bladder, provide one assistance for catheter care, report signs of UTI (Urinary Tract Infections-acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine), store collection bag inside a protective dignity pouch, and use a catheter strap. The care plan lacked any mention of an urethral erosion that the resident experienced, or what staff were to do to protect the remaining urethra.

Review of a physician progress note, dated 11/18/13 revealed the resident reported the catheter being pulled and identified the urethra opening was getting larger/worse. The note identified the physician talked with staff about taking extra precautions when transferring the patient and making sure the catheter was secured without tension. This information was not included on the care plan.

On 12/17/13 at 7:05 a.m., observation revealed direct care staff V provided catheter care to the resident. Observation of the resident's urethra

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 27	F 279		

revealed a large erosion and a slight amount of blood. When asked how long the resident had the erosion, staff V stated they were not aware, they had not worked with the resident for a few weeks. When asked if the resident had the erosion the last time he/she worked with the resident, staff V stated no, the resident did not. Licensed nurse W then came into the room and staff V showed the urethral erosion to nurse W and asked the nurse if that was new. The nurse stated that he/she did not know and would need to go check the resident's chart.

On 12/16/13 at 3:20 p.m., the resident stated the urethral erosion has gotten worse since he/she came into the facility, and it was because the staff did not pay attention when they helped him/her get dressed each day and it would pull.

On 12/16/13 at 4:35 p.m., direct care staff U stated he/she did not need to do anything special for the resident other than to encourage the resident to do as much for himself/herself as possible.

On 12/17/13 at 10:25 a.m., Licensed nurse W , stated the urethral erosion was not new for the resident, that he/she came into the facility with it. When asked what staff were to do to protect it from getting worse, nurse W stated they were to use a leg strap to prevent pulling.

On 12/17/13 at 12:30 p.m., Administrative nurse P stated he/she was responsible for the development of the resident's care plan. Nurse P stated the resident had come into the facility with the urethral erosion, but stated he/she had not put that information on the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 279	Continued From page 28	F 279		

Review of the facility's undated Comprehensive Care Plan policy revealed the following: It is the policy of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ...3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident.

The facility failed to develop an individualized care plan for a resident with an indwelling urinary catheter and a urethral erosion.

- Review of resident #193's physician order sheet dated 11-21-13 revealed a diagnosis of anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and insomnia (inability to sleep).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 11-27-13 revealed a BIMS (Brief Interview for mental Status) score of 13 indicating cognitively intact. The MDS also identified the resident received an antianxiety medication 6 out of 7 days, an antidepressant 7 out of 7 days, and a hypnotic 2 out of the past 7 days.

Review of the psychotropic medication CAA (Care Area Assessment) dated 12-3-13 revealed an analysis of findings that the resident received Restoril (a hypnotic sleeping medication) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 29	F 279		

insomnia, Zoloft (an antidepressant) and Xanax (Alprazolam, an antianxiety medication) for depression with anxiety.

Review of the care plan dated 12-4-13 identified the resident received an antidepressant medication with interventions to assess/record effectiveness of drug treatment, monitor for side effects, monitor resident mood and response to medications, and consult pharmacy. It failed to identify specific targeted symptoms for the staff to monitor.

The care plan also identified the resident received an antianxiety medication related to depression with anxiety and directed staff to monitor for drug use effectiveness and adverse consequences, and document the resident's behavior/mood. It failed to specifically identify targeted behavior for staff to monitor and failed to direct staff on non-pharmacological interventions to use prior to administering the medication.

The same care plan identified the resident received a hypnotic medication related to insomnia and anxiety and directed staff to assess/record effectiveness of drug treatment, monitor and report adverse side effects. It also directed staff to attempt non-pharmacological interventions such as repositioning, toileting the resident and offering the resident a drink or snack. The care plan failed to identify specific targeted behaviors and interventions regarding sleep hygiene.

On 12-17-13 at 12:16 p.m. administrative nursing staff P stated when developing the care plan for a resident who received psychotropic medications the psychotropic CAA would trigger and he/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 30	F 279		

would work through that to develop the care plan. Staff P stated the facility did not do sleep assessments to identify what kind of things the resident did at home to help sleep or what kind of things they did to reduce anxiety. Staff P stated that he/she had not identified individual behaviors or reactions regarding anxiety or insomnia.

Review of the facility ' s Comprehensive Care Plan policy with no revision date, revealed the following: It is the policy of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ...3. Each resident ' s care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident.

The facility failed to comprehensively develop the care plan for a resident who received antianxiety, antidepressant, and hypnotic medications to identify the resident ' s expressions of anxiety, depression, or insomnia in order for staff to effectively monitor the need for the medication.

- Review of resident #50's physician order sheet dated 11-10-13 included diagnosis of agitation, dementia with agitation (Dementia- progressive mental disorder characterized by failing memory, confusion), and nonorganic psychosis (any major mental disorder characterized by a gross impairment in reality testing).

Review of the quarterly MDS dated 10-20-13 revealed BIMS score of 8 indicating moderate cognitive impairment. The MDS also identified the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 31	F 279		

resident had delusions but no other behaviors. It included current diagnoses of dementia, depression, and psychotic disorder. It also revealed the resident received an antipsychotic and antidepressant medication 7 out of the past 7 days.

Review of the care plan last reviewed on 10-31-13 revealed the resident received an antidepressant medication and an antipsychotic medication. The care plan directed staff to monitor and report signs of sedation and or extrapyramidal symptoms (movement disorders as a result of taking certain medications). Staff was to monitor the president's behavior and response to medication, pharmacy consultant review quarterly, assess/record effectiveness of medication, monitor for adverse side effects, and attempt non-pharmacological interventions. The care plan did not identify what behaviors to monitor for staff to evaluate effectiveness of medication and did not identify non-pharmacological interventions to try.

On 12-17-13 at 10:01 a.m. direct care staff DD stated the resident would sometimes yell out and could get aggressive/combative with staff during care.

On 12-17-13 at 12:16 p.m. administrative nursing staff P stated when developing the care plan for a resident who received psychotropic medications the psychotropic CAA would trigger and would work through that to develop the care plan. Staff P stated the facility did not do assessments to identify how the resident expressed anxiety or what the resident did to reduce anxiety. Staff P stated that he/she had not identified individual behaviors or reactions regarding anxiety or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 32	F 279		

behaviors related to the resident ' s dementia.

Requested a policy regarding the development of care plans on 12-18-13 and the facility did not provide one.

The facility failed to comprehensively develop the care plan for a resident who received antianxiety, antidepressant, and hypnotic medications to identify the resident ' s expressions of anxiety, depression, or insomnia in order for staff to effectively monitor the need for the medication.

- Resident #40 was admitted on 11-14-13 with a diagnosis of type 2 Diabetes (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin), end stage renal disease (a kidney disease that is terminal because of irreversible damage to vital tissues or organs), and required Dialysis (a procedure which filters the blood).

Review of the admission MDS (minimum data set) dated 11-21-13 revealed a BIMS (brief interview for mental status) score of 6 (severe cognitive impairment). The resident required extensive assistance of one staff for bed mobility, transfers, toilet use, dressing, personal hygiene and received dialysis treatments.

Review of the care plan for dialysis dated 12-2-13 revealed the resident required dialysis and would not exhibit signs of fluid volume excess and directed staff to assess for fluid excess, assure medications are administered before and after dialysis ordered by the physician, diet CCHO (controlled carbohydrates) with added protein, monitor lab work and request copies from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 33	F 279		

dialysis center if lab is done there, monitor weight as MD (medical doctor - physician) orders and Notify physician of sudden weight gain or increased blood pressure. The care plan lacked direction to staff to monitor the shunt site after dialysis treatments.

During an interview on 12-17-13 at 8:38 AM administrative nursing staff A reported nursing staff are responsible for assessment of the fistula daily as well as maintain communication with the dialysis treatment center which should be on the resident's plan of care. Staff A also reported nurse staff should be aware by communication with the resident of how the dialysis treatment was and if there were any concerns from the resident. Staff A found no dialysis communication tool or nurse assessments of the fistula in the medical records.

The facility failed to develop a comprehensive plan of care for monitoring of a shunt site, communication with the dialysis treatment center for effective coordination of care, for a resident who received dialysis treatments.

- Review of resident #41's annual MDS (minimum data set) dated 4/6/13 revealed a BIMS (brief interview for mental status) score of 14, indicating no cognitive impairment. The resident required limited assistance of one staff for transfers, supervision with setup assistance for eating, and extensive assistance of one staff for locomotion on and off the unit. The resident indicated it was very important to choose his/her own bedtime.

Review of the quarterly MDS dated 10/7/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 34	F 279		

revealed a BIMS score of 14, indicating no cognitive impairment. The resident required supervision with setup assistance for transfers and eating, the resident did not walk, and required extensive assistance of one staff for locomotion on and off the unit.

Review of the CAAs (care area assessments) dated 4/17/13 revealed the Communication and Cognitive Loss/Dementia areas had not triggered

Review of the resident's care plan, reviewed 10/21/13, revealed the care plan lacked any information regarding the resident's sleep patterns.

Review of an Admission Activity Assessment dated 3/13/12 revealed staff interviewed the resident about his/her preferred wake and sleep times. The assessment did not indicate any special bedtime routines.

Observation on 12/16/13 at 6:14 a.m. revealed the resident sat sleeping in a wheelchair in his/her room. The resident wore his/her pajamas. The resident's bed was made.

Observation on 12/16/13 at 7:29 a.m. revealed the resident sat in his/her wheelchair and was awake.

Observation on 12/17/13 at 7:19 a.m. revealed the resident sat awake in the dining room dressed for the day.

Interview with the resident on 12/16/13 at 11:04 a.m. revealed he/she would like to sleep in his/her bed, but he/she usually fell asleep in the wheelchair. The resident reported staff did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 35	F 279		

offer to help him/her to bed and reported he/she could not crawl into bed him/herself. The resident reported his/her back was starting to hurt from sleeping in the wheelchair so much.

Interview with direct care staff LL on 12/16/13 at 1:52 p.m. revealed the resident did not tell us when he/she wanted to get up in the morning and he/she slept all night in his/her wheelchair frequently.

Interview with direct care staff T on 12/16/13 at 3:15 p.m. revealed staff had to assist the resident to go to bed.

Interview on 12/17/13 at 7:20 a.m. with direct care staff V revealed he/she worked night shift at times and the resident liked to sit in front of the television in the wheelchair, watch the home shopping channel, and write things down. Staff V reported he/she offered to put the resident in bed when he/she worked night shift because the resident frequently fell asleep in his/her wheelchair. Staff V reported usually the resident refused because he/she could not see the television well enough from the bed to write down the numbers.

Interview with licensed nursing staff KK on 12/16/13 at 4:53 p.m. revealed the resident was frequently up sleeping in the wheelchair when the first shift came in.

Interview on 12/17/13 at 9:17 a.m. with licensed nursing staff P revealed staff did not specifically care plan for wake and sleep times because the staff were expected to ask the residents, however he/she would expect the care plan to include that the resident liked to stay up in his/her chair to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 279	Continued From page 36 sleep. Interview on 12/17/13 at 1:01 p.m. with administrative nursing staff A revealed he/she expected it to be in the resident's care plan that he/she liked to sleep in the wheelchair and refused to go to bed. Review of the facility ' s undated Comprehensive Care Plan policy revealed the following: It is the policy of the facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ...3. Each resident ' s care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident. The facility failed to individualize the resident's comprehensive care plan to include that the resident slept in his/her wheelchair frequently and sometimes refused to go to bed.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 309	Continued From page 37	F 309		

The facility had a census of 72 with 23 sampled residents. One of the 23 sampled residents was reviewed for dialysis. Based on observation, record review, and interview the facility failed to provide the necessary daily monitoring and failed to communicate care with the outside dialysis facility in order to maintain the highest practicable standards of care for a resident who received dialysis services. (#40)

Findings included:

- Resident #40 was admitted on 11-14-13 with a diagnosis of type 2 Diabetes (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin), end stage renal disease (a kidney disease that is terminal because of irreversible damage to vital tissues or organs), Dialysis (a procedure which filters the blood).

Review of the admission MDS (minimum data set) dated 11-21-13 revealed a BIMS (brief interview for mental status) score of 6 (severe cognitive impairment). The resident required extensive assistance of one staff for bed mobility, transfers, toilet use, dressing, personal hygiene and received dialysis treatments.

Review of the CAA (care area assessments) revealed no CAA was developed for dialysis.

Review of the ADL care plan dated 12-2-13 revealed the resident's ability to perform ADL's (activities of daily living) independently had deteriorated related to weakness and pain from a fractured left shoulder with co-morbidities of DM (diabetes mellitus), COPD (chronic obstructive pulmonary disease - a lung disease process)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 309	Continued From page 38	F 309		

HTN (hypertension - high blood pressure), and diabetic neuropathy (numbness in the feet caused by diabetic disease process) and directed staff to not rush and allow extra time to complete ADL's, resident is non-weight bearing with left arm.

Review of the care plan for dialysis dated 12-2-13 revealed the resident required dialysis and would not exhibit signs of fluid volume excess and directed staff to assess for fluid excess, assure medications are administered before and after dialysis ordered by the physician, diet CCHO (controlled carbohydrates) with added protein, monitor lab work and request copies from the dialysis center if lab is done there, monitor weight as MD (medical doctor - physician) orders and Notify physician of sudden weight gain or increased blood pressure. The care plan lacked directed to staff to monitor the shunt site after dialysis treatments.

Review of the physicians orders dated 11-10-13 revealed the resident is to have dialysis MWF (Monday, Wednesday, Friday) at 6 am at a local dialysis center, keep incision to LUE (left upper extremity) clean/dry - no lotions or ointments to incision.

Review of the resident's medical records revealed no "dialysis communication tool" forms which are used to communicate with the dialysis treatment center. The forms include pertinent medical information with regards to each treatment including, medication given by the facility prior to treatment, medications sent with the resident, concerns since the last visit and dialysis facility information such as weights before and after treatment, labs drawn, any complications,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 309	Continued From page 39	F 309		

medications administered during treatment, and condition of the shunt site(access site)/dressing.

Review of the daily nursing assessment documents located in the resident's medical chart revealed no documentation of assessments of the residents fistula daily or after dialysis treatments and no facility dialysis communication tool forms (used for communication of pertinent resident medical information between the facility and the dialysis treatment center)

Observation of the resident on 12/12/13 at 10:43 AM revealed he/she had a fistula (a implanted device used for dialysis treatment) in his/her upper left arm. The area around the fistula was slightly reddened with a bluish bruised appearance.

Observation of the resident on 12/16/2013 at 11:17 AM revealed he/she left for dialysis.

During an interview on 12/12/2013 at 10:43 AM the resident revealed he/she went for dialysis on, Monday, Wednesday and Fridays. The resident reported he/she returned in the late afternoons. The fistula on the left upper arm is protected with a dresing from the dialysis facility which the resident removes him/herself. The resident reported he/she was knowledgeable on the procedure necessary if there was a problem with blood leaking from the fistula and would call a nurse if that happened, otherwise, he/she reported the staff do not monitor the fistula daily or upon return to the facility.

During an interview on 12-17-13 at 7:44 AM licensed nurse staff EE reported the resident went to dialysis on Monday, Wednesday, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 309	Continued From page 40	F 309		

Fridays, and had a fistula in his/her upper left arm. Staff EE reported he/she assessed the fistula once a shift and if the site began to leak body fluids, he/she would hold pressure until the bleeding stopped then notify the physician. Staff reported he/she did not document the assessment unless there was a problem. Staff reported he/she checked the fistula yesterday.

During an interview on 12-17-13 at 8:38 AM administrative nursing staff A reported nursing staff are responsible for assessment of the fistula daily as well as maintain communication with the dialysis treatment center which should be on the plan of care. Staff A also reported nurse staff should be aware by communication with the resident of how the dialysis treatment was and if there were any concerns from the resident. Staff A found no dialysis communication tool or nurse assessments of the fistula in the medical records.

Review of the facility Hemo-Dialysis policy (undated) revealed the facility will provide a comprehensive plan of care to include collaborative cooperation with the dialysis unit and include information transmitted to the dialysis unit by the facility prior to dialysis and information transmitted to the facility by the dialysis unit after dialysis. The policy further indicated the resident's general care at the facility will consist of no blood pressure in the affected arm, assess thrill and bruit (feel and sound of a shunt/fistula) every shift and record, assess for signs of infection. Post dialysis included when the resident returned from dialysis, assess the shunt site for bleeding and ensure blood pressure was stable before allowed resumption of normal activity, remove gauze dressing within 4 to 6 hours following treatment, remove bandaids next morning, monitor dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 309	Continued From page 41 The facility failed to maintain the standard of care by failed communication with a local dialysis treatment center who provided medical treatment and failed nurse assessments of a fistula to maintain and prevent any complications in medical care for resident #40.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents with 23 included in the sample. Based on observation, interview, and record review, the facility failed to provide nail care and facial hair grooming for 1 of 3 residents reviewed for ADL (activities of daily living) assistance and to provide oral care for 1 of 3 reviewed for dental services. (#41, 39) Findings included: - Review of resident #41's annual MDS (minimum data set) dated 4/6/13 revealed a BIMS (brief interview for mental status) score of 14, indicating no cognitive impairment. The resident required limited assistance of one staff for transfers, supervision with setup assistance for walking in his/her room, walking in the corridor, and personal hygiene, and extensive	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 312	Continued From page 42	F 312		

assistance of one staff for locomotion on and off the unit.

Review of the quarterly MDS dated 10/7/13 revealed a BIMS score of 14, indicating no cognitive impairment. The resident required supervision with setup assistance for transfers and personal hygiene, and extensive assistance of one staff for locomotion on and off the unit. The resident did not walk.

Review of the ADL Functional/Rehabilitation Potential CAA (care area assessment) dated 4/17/13 revealed the resident required supervision to limited assistance with most of his/her ADLs. The resident could make his/her needs know and used the call light. The resident used a wheelchair at times.

Review of the resident's care plan last reviewed on 10/21/13, revealed the resident was to have his/her nails cleaned, filed, and painted by activities staff. The care plan did not include interventions regarding the resident's facial hair removal.

Review of an ADL Documentation sheet for 12/9/13-12/15/13 revealed the resident required limited assistance of one person for personal hygiene.

Review of the Shower/Bath Sheets from October 2013 - December 16, 2013 revealed the sheets did not indicate if the resident had his/her facial hair shaven or fingernails cleaned or trimmed.

Review of a December 2013 Activity Calendar revealed manicures were scheduled for 3:00 p.m. on 12/15/13 and 12/29/13 for the house the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 312	Continued From page 43	F 312		

resident resided in.

Review of a Activity Flow Sheet for December 2013 revealed the resident participated in manicures on 12/1/13.

Observation on 12/10/13 at 3:37 p.m. revealed the resident had long fingernails with jagged edges and chipped fingernail paint. The resident also had approximately 1/4 inch whiskers on his/her upper lip and chin.

Observation on 12/12/13 at 3:00 p.m. revealed the resident's fingernails long with jagged edges and chipped fingernail paint. The resident also had whiskers approximately 1/4" long on his/her upper lip and chin.

Observation on 12/16/13 at 11:02 a.m. revealed the resident's fingernails were still long and had jagged edges and his/her facial hair was not removed.

Interview with the resident on 12/17/13 at 10:59 a.m. revealed usually the activity staff painted his/her fingernails on Sunday. The resident reported the activity staff had not been around in a while and his/her fingernails were in a mess right now. The resident reported he/she had tried to take the paint off of one finger and it took him/her over a half an hour.

Interview with direct care staff LL on 12/16/13 at 1:52 p.m. revealed the resident had "gone down hill". Staff reported he/she had not seen the resident do anything with his/her own fingernails. Staff reported he/she shaved and provided nail care during a shower if a resident asked, but not routinely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 312	Continued From page 44	F 312		

Interview with direct care staff T on 12/16/13 at 3:15 p.m. revealed the nurse provided nail care for the resident because the resident was diabetic. Staff reported he/she did not shave the resident's facial hair. Staff confirmed the resident could not shave his/her face or paint his/her own fingernails.

Interview with licensed nursing staff KK on 12/16/13 at 4:53 p.m. revealed he/she expected the aides to provide grooming including facial hair removal during the resident's shower. Staff reported the nurse only provided nail care for diabetics when the aides told the nurse it needed done. Staff reported the activities staff could paint the resident's fingernails.

Interview on 12/17/13 at 10:49 a.m. with licensed nursing staff W revealed the nurses and podiatrist provided nail care as needed for diabetic residents.

Interview with activity staff R on 12/17/13 at 10:25 a.m. revealed nail care was scheduled for every other week in each house and then the activity staff provided it between times if needed. Staff reported the nurse trimmed diabetic nails, but the activity staff could file and paint the resident's fingernails. Staff did not know when the last time the resident had his/her nails filed and painted. Staff reported activity staff did not document when nail care was provided.

Interview on 12/17/13 at 9:17 a.m. licensed nursing staff P revealed staff did not include facial hair grooming on the care plan because it was just expected as a standard of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 312	Continued From page 45	F 312		

Interview on 12/17/13 at 1:01 p.m. with administrative nursing staff A revealed he/she expected nurses to provide nail care whenever the resident or the aide let them know they needed it and the facility had two nurse practitioners in the building Monday-Friday who could also provide diabetic nail care. Staff reported the activities staff were allowed to file the diabetic resident's nails and paint them. Staff reported he/she expected for facial hair grooming to be done with the resident's baths and as needed.

Review of the facility's undated policy for Shower/Tub Bath revealed staff were not to trim the resident's toenails or fingernails unless otherwise instructed by the nurse. The policy lacked guidance for shaving residents.

Review of the facility's undated policy for Nail Care revealed all resident's in the facility were to receive appropriate finger and toenail care on a regularly scheduled basis. The nail care would be provided by a licensed nurse or physician for residents with diabetes. Residents with restrictions or special instructions in providing nail care would be noted in the resident's care plan.

The facility failed to provide nail care and facial hair grooming for a resident requiring assistance.
- Review of resident #39's admission record, dated 9/19/13, identified the resident had diagnosis of dementia with behavior disturbances (a progressive mental disorder characterized by failing memory, confusion, with accompanying behaviors).

Review of the significant change MDS (Minimum Data Set-a required assessment) dated 6/1/13,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 312	Continued From page 46	F 312		

revealed the resident had short and long-term memory problems, severely impaired cognition, no behaviors (including rejection of care), dependent on one staff for personal hygiene, and with obvious or likely cavities or broken teeth.

Review of the dental CAA dated 6/11/13 revealed the resident needed one person assistance with oral care, and identified staff planned to monitor the resident's oral cavity for any abnormal mouth tissue.

Review of the dental care plan, dated 12/27/12 and updated on 12/10/13 identified that the resident had broken, loose, or carious teeth related to the natural aging process and directed staff to provide one staff member for assistance for oral hygiene care and staff may consult dentist as needed.

Review of physician orders, signed on 11/4/13, identified the resident was to receive a full liquid diet.

Review of a quarterly dental assessment dated 12/9/13 identified the resident as alert, nonverbal, and unable to follow commands secondary to disease process. Immediate recent and past mental status impaired. It identified the resident had natural broken teeth but staff were unable to fully assess the resident's oral status due to current mental status.

Review of a pain assessment dated 12/3/13 described the resident as unable to express pain.

Observation on 12/12/13 at 10:17 a.m. revealed the resident lay in bed on his/her back. Observation of the resident's bathroom revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 312	Continued From page 47	F 312		

an unmarked electric toothbrush in a stand, as well as 2 unmarked toothbrushes located in a holder. The resident shared a room with his/her spouse. None of the toothbrushes appeared wet, or recently used. There was also a half-used rolled up tube of toothpaste on the sink as well as a half-full bottle of mouth rinse with a child-proof cap.

On 12/16/13 at 7:18 a.m., direct care staff B assisted the resident to get dressed and up for the day. At 7:22 a.m., direct care staff I entered the room and assisted staff B to change the resident's wet incontinent brief, then dress the resident, then used a mechanical lift to transfer the resident from the bed to the wheelchair. Staff B obtained a wet washcloth to wash the resident's face and used a pick to comb the resident's hair. Staff B then positioned the resident in the wheelchair next to the resident's bed and left the room. The staff failed to provide oral hygiene to the resident.

On 12/16/13 at 8:12 a.m., observation revealed direct care staff B entered the resident's room and pushed the resident from the bed to the dining room for breakfast. Once at the dining room, Licensed nurse JJ sat down with the resident with a 4 oz (ounce) container of yogurt and an 8 oz healthshake and spent some time with the resident, trying to get him/her to eat breakfast. The resident's spouse sat with him/her and tried to encourage the resident to eat. The resident did not open his/her mouth much to eat.

On 12/16/13 at 9:05 a.m., observation revealed direct care staff S and direct care staff B assisted the resident from the dining room after the resident ate half of the yogurt and half of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 312	Continued From page 48	F 312		

healthshake. Staff S and B used a mechanical lift and transferred the resident from the wheelchair into bed, situated the resident for comfort, then left the room. The staff did not assist the resident to brush his/her teeth.

On 12/16/13 at 10:35 a.m., the resident's spouse, who shared the same room with the resident, stated that there were 2 regular toothbrushes and one electric toothbrush in the bathroom for use. When asked which one belonged to the resident since none of them were marked, the spouse laughed and said "I really don't know, they have gotten all mixed up." The spouse said the staff would try to brush the resident's teeth "sometimes" but that the resident did not really want to allow it because he/she did not understand what was going on, and that was hard. The spouse said that he/she did not know if the resident's teeth bothered him/her or not, but the resident had missing front teeth, and he/she could not remember if they had been pulled or if they had fallen out.

On 12/16/13 at 4:52 p.m., direct care staff Q described the resident as dependent on staff for all ADLs (Activities of Daily Living), including brushing the teeth, and staff are to brush his/her teeth every night.

On 12/17/13 at 10:42 a.m., direct care staff B stated the resident was dependent on staff for all cares, including brushing his/her teeth and said staff were to brush the resident's teeth every day, in the morning, when they help the resident up.

On 12/17/13, at 2:10 p.m., Administrative Nurse A lacked an explanation as to why staff did not routinely assist a dependent resident with the oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 312	Continued From page 49 hygiene. The facility staff failed to routinely assist a dependent resident with broken, carious teeth with daily oral hygiene, including teeth brushing.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 72 with 23 sampled residents. One of the 23 residents were reviewed for pressure ulcers. Based on observation, record review and interview the facility failed to ensure a resident with an on going history as well as current pressure ulcers received necessary treatment and services to promote healing, and prevent new sores from developing by failure to provide timely repositioning for resident #30. Findings included: - Resident #30 was admitted to the facility on 11/8/13 with a diagnosis of muscle weakness, difficulty walking, depression, type 2 diabetes (a condition where the body is unable to produce enough insulin), dementia, pain, and a venous	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 314	Continued From page 50	F 314		

stasis ulcer to the left heel (a wound caused from poor circulation), a stage 2 pressure ulcer on the coccyx (a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction - located on the tailbone).

Review of the admission MDS (minimum data set) dated 11/20/13 revealed a BIMS (brief interview for mental status) score of 4 (severe cognitive impairment). The resident required extensive assistance of 1 staff for bed mobility, dressing, eating, personal hygiene and extensive assist of 2 staff for transfers. The resident was occasionally incontinent of bladder and always continent of bowel, was at risk for pressure ulcers, had 1 stage 2 pressure ulcer with granulation on admission and 1 venous stasis ulcer on admission.

Review of the pressure ulcer CAA (care area assessment) dated 11/21/13 revealed the resident has a stage 2 pressure area to buttocks with treatment order of Mepilex border (padded dressing) changed every 2 days and PRN (as needed). The resident also had a venous stasis ulcer to the left heel with the same order as above, both areas were present on admission.

Review of the pressure ulcer care plan dated 11/28/13 revealed the resident had recurring area to coccyx which was currently closed and directed staff to assist with repositioning and perform skin assessments per protocol (facility policy), pay special attention to the feet, and encourage resident to sleep in his/her bed. The care plan further revealed the resident had a venous ulcer related to poor circulation with PVD (peripheral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 314	Continued From page 51	F 314		

vascular disease), located on the left heel, with measurements of 4 x 3 cm(centimeters) black area, and 4 x 5 cm total opened area. The goal was pain controlled and directed staff to administer pain medications. Heel protector worn at all times as tolerated. The care plan was revised 12-4-13 to include a pressure relief to air bed and chair cushion, and a treatment change of clean with normal saline (salt and water solution), apply polyox powder (powdered medication), cover wound with off loading dressing (thick soft to relieve pressure), change daily and PRN, and give ampicillin (antibiotic) 500 mg (milligrams) po (by mouth) bid (twice daily) for 10 days (for infection).

Observations on 12-16-13 at 6:16 AM, 6:29 AM, 6:43 AM, 7:01 AM, 7:17 AM, 7:36 AM, 7:55 AM, 8:14 AM, 8:32 AM, 8:44 AM, 9:01 AM, and 9:13 AM revealed the resident lay in his/her bed on his/her back and slept. The resident had an air mattress and large soft blue boots on both feet with the left foot turned inward. The resident lay in the same position during the time period without repositioning him/herself and no staff was observed repositioning the resident.

Observation on 12-16-13 at 9:13 AM, after asking staff to check the resident's skin, revealed the resident's buttock area had a quarter size white area located between the buttocks. The surrounding perineal and skin area had reddened wrinkled skin folds directly on the buttock area and around the coccyx and reddened skin area just at the top of the buttock area which spanned from the left side to the right side approximately 6 to 8 inches across and 3 to 4 inches wide oval shape.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 314	Continued From page 52	F 314		

Observation on 12-16-13 at 12:33 PM, 12:48 PM, 1:01 PM, 1:13 PM (at dining table), 1:24 PM (moved to room), 1:42 PM (asleep in wheelchair), 1:58 PM, 2:13 PM (asleep in wheelchair), 2:44 PM (asleep in wheelchair), and 3:03 PM revealed the resident sat in his/her wheelchiar on a pressure relief cushion, with the left foot in the pressure relief boot with both feet on the foot pedals of the wheelchair. Observation at 3:27 PM resident was transferred by two staff with mechanical lift to his/her recliner chair for a dressing change by the nurse.

During an interview 12-16-13 at 9:13 AM staff PP and RR reported the unit is a heavy unit with residents who require a lot of assistance. There is not enough staff to accommodate the needs of the residents especially in the mornings when the residents are supposed to be out for breakfast and some get showers before breakfast, as well as some use lifts which require two staff. Staff reported they needed one more staff to assist the other residents when the two of them are in one room with a resident who requires two assist. Staff PP reported he/she had not been the residents room yet this morning due to assisting the other residents.

Interview on 12/16/2013 at 2:45 PM direct care staff PP reported the resident required a sit to stand mechanical lift or two person for transfers, was incontinent most of the time, had an open wound on left heel, and should be turned every two hours.

Interview on 12-16-13 at 4:48 PM licensed nurse staff FF reported he/she monitored staff and made sure they were toileting, turning and providing necessary cares for the residents on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 314	Continued From page 53	F 314		

unit by walking rounds. Staff FF stated he/she visited each resident room once a day. Staff FF reported there were no residents on the unit that were not moved or changed position at least every two hours due to having them out for breakfast, lunch and dinner as well as other activities.

During an interview on 12-17-13 at 10:54 AM physician OO stated the resident came to the facility with the existing ulcers, and had a meeting with the family held on 11-27-13 which entailed how agressive they wanted treatment for the resident. The family did not want any venous studies or invasive treatments done at the time so staff had orders to offload the heel wound and reposition the resident.

Review of the repositioning (undated) facility policy revealed each resident who had a pressure ulcer or is at risk of developing one will be repositioned to relieve pressure at specifically identified areas. After assessment of the residents skin and analysis of effect of pressure, interventions will be developed and documented on the individual's care plan. A resident who had an existing pressure ulcer should not be positioned on that area as it may impede (slow down) healing. A resident who was dependent on the staff for position changes may need position changes every two hours or more frequently depending on their tolerance of pressure identified by assessment, may need position changed every hour is the head of the bed is elevated.

The facility failed to ensure and provide necessary care such as turning and repositioning for a resident who was identified as a high risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 314	Continued From page 54 pressure ulcers.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents with 23 included in the sample. The sample included the review of 2 residents with indwelling urinary catheters. Based on observation, interview and record review, the facility failed to provide appropriate care and services to prevent urinary tract infections for 2 of 2 sampled residents with indwelling urinary catheters. (#119 and #33) Findings included: - Review of resident #33's review of physician's orders, signed on 11/15/13, identified the resident with the diagnosis of weakness. Review of the Annual MDS (Minimum Data Set-a required assessment), dated 4/11/13, identified the resident with short and long-term memory problems, severely impaired cognition, dependent on one staff for bed mobility, personal hygiene,	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 315	Continued From page 55	F 315		

dependent on two staff for transfers, toileting, and with an indwelling urinary catheter.

Review of the quarterly MDS dated 10/12/13 identified the resident with short and long-term memory problems, severely impaired cognition, dependent on one staff for bed mobility, personal hygiene, dependent on two staff for transfers, toileting, and with an indwelling urinary catheter.

Review of the Urinary Incontinence/Indwelling Catheter CAA (Care Area Assessment-a further assessment dated 4/25/13, identified the resident had an indwelling urinary catheter due to an incompetent urethra and neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

Review of the care plan for indwelling urinary catheter, dated 1/18/11 and reviewed on 1/18/12, revealed the resident required an indwelling urinary catheter related to an incompetent urethra and neurogenic bladder. The care plan directed staff to assess drainage, record the amount/type/color/odor; observe for leakage, avoid lying the resident on top of the tubing, change catheter bag every month, change catheter per doctor's order, do not allow tubing or any part of the drainage system to touch the floor. Keep catheter system a closed system as much as possible, position bag below level of bladder, provide one assistance for catheter care, report UTI (Urinary Tract Infection--acute confusion, urgency, frequency, bladder spasms, nocturia (urinating at night), burning, pain, difficulty urinating, low back/flank pain, malaise (weakness), nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine), use a catheter strap, and assure enough slack is left in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 315	Continued From page 56	F 315		

the catheter between the meatus and strap.

Observation on 12/16/13 at 3:07 p.m. revealed the resident lay in bed in his/her room, on his/her back, with the head of the bed elevated to a 45 degree angle, sleeping. The bed was in the lowest position and the catheter collection bag lay directly on the floor.

On 12/17/13 at 8:50 a.m., direct care staff L pushed the resident from the dining room table back to his/her room. Once there, staff L detached the catheter collection bag from where it hung at the back of the wheelchair and tossed it on the floor underneath the resident's wheelchair, then walked to the front of the wheelchair, picked up the catheter collection bag and hung it on the side of the wheelchair.

On 12/17/13 at 9:52 a.m., Licensed nurse W said staff were to "absolutely not" place the catheter collection bag on the floor.

Review of the facility's undated catheter care policy provided the following guidance to staff: "Never let the drainage bag touch the floor (which is considered unclean)."

The facility failed to follow their policy and allowed the catheter collection bag to touch the floor for a resident with an indwelling urinary catheter.

- Review of resident #119's physician's review of orders, signed on 12/16/13, revealed the resident had diagnoses of wound care and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk).

Review of the admission MDS (Minimum Data

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 315	Continued From page 57	F 315		

Set-a required assessment) dated 11/5/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15, indicating the resident had little to no cognitive impairment, no behaviors (including refusing care), required the extensive assistance from two staff with transfers, bed mobility, toileting, required extensive assistance from one staff for personal hygiene, and identified the resident had an indwelling urinary catheter.

Review of the Urinary Incontinence/Indwelling Catheter CAA (Care Area Assessment-a further assessment) dated 11/6/13, revealed the resident had a Foley catheter due to paraplegia and needed one person assistance for personal care.

Review of the indwelling urinary catheter care plan, dated 11/18/13 revealed the resident required an indwelling urinary catheter related to chronic urinary retention due to paraplegia. The care plan directed staff to avoid obstructions in the drainage system, change catheter per doctor's order, keep catheter system a closed system as much as possible, position bag below level of bladder, provide one assistance for catheter care, report signs of UTI (Urinary Tract Infections-acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine), store collection bag inside a protective dignity pouch, and use a catheter strap.

On 12/16/13 at 4:35 p.m., direct care staff T and direct care staff U prepared to assist the resident with a transfer from the bed to the wheelchair with a slide board. Staff U emptied the catheter collection bag by getting a urinal and unhooking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 315	Continued From page 58	F 315		

the drain spout from the catheter collection bag and emptying the urine into the urinal. When finished emptying, staff U tapped the spout against the edge of the urinal, then replaced the spout in the holder. Staff U never cleansed the spout. .

On 12/17/13 at 7:05 a.m., observation revealed direct care staff G entered the resident's room and the resident told staff G to check his/her catheter, he/she thought it needed emptying. Staff G looked at the collection bag and obtained the urinal, then removed the drain spout and emptied the urine into the urinal. When empty, staff G replaced the drain spout into the holder, and never cleansed the drain spout. Staff G emptied the urinal, and came back and assisted the resident to dress for the day.

On 12/16/13 at 4:35 p.m., staff U stated when doing catheter care for the resident he/she waited "until the nurse is done with him/her and tells [staff U] it is ok to do it." Staff U said that the last time he/she provided catheter care was about 2 days ago, but he/she thought it was supposed to be done once every shift.

On 12/17/13 at 7:35 a.m., direct care staff G, stated that he/she had not done the resident's catheter care for weeks. He/she does not normally work this house.

On 12/17/13 at 9:52 a.m., Licensed nurse W described what staff were to do when emptying the catheter collection bag: staff were to clean the spigot with alcohol wipes to keep it clean and prevent bacteria.

Review of the facility's undated policy on Urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 315	Continued From page 59 Drainage Bags revealed guidance to staff to use an alcohol wipe on the tubing when emptying the drainage bag, because extreme care must be maintained to protect from the introduction of bacteria into the system. The facility failed to ensure staff cleansed the drainage spout when emptying a catheter collection bag to prevent urinary tract infections for a resident with an indwelling urinary catheter.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents with 23 included i nthe sample. The sample included the review of 4 resident with accidents. Based on observation, interview and record review, the facility failed to determine the root cause of falls in order to develop effective interventions that included suffiecient supervision and assistive devices to prevent additional falls for 2 of 4 sampled residents. (#19 and #189) Findings included: - Review of resident #19's physician orders, signed by the physician as 12/13, identified the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 323	Continued From page 60	F 323		

resident with the diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).

Review of the significant change MDS (Minimum Data Set-a required assessment) dated 10/30/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 4/15 (indicating severely impaired cognition), rejected care 1-3 days of the 7 day assessment, required extensive assistance from two staff for bed mobility, transfers, dependent on one staff for locomotion on/off the unit, had over 2 non-injury falls and over 2 falls with minor injury since the last assessment.

Review of the Fall CAA (Care Area Assessment) dated 11/13/13, identified the resident had multiple falls over the last quarter, was recently treated for UTI (Urinary Tract Infections), and was admitted to hospice services. The CAA also identified the resident required a mechanical lift for transfers and staff assistance for all ADLs (Activities of Daily Living).

Review of the fall care plan for the resident, last reviewed on 11/21/13 identified the resident had a history of falling related to weakness, and directed staff to have physical therapy evaluate the resident for use of lift chair, not give the resident access to recliner remote when up in chair, hospice aide will visit 3 times a week to do one on ones with the resident, encourage the resident to watch TV in common areas, bed rails for mobility, floor mat at bedside, toilet prior to or after meals, Toilet prior to end of shift, one on one program with activities, mechanical lift for transfers with 2 person assistance, concave mattress, wheelchair alarm placed out of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 323	Continued From page 61	F 323		

resident's view/reach, and a bed/chair alarm for his/her safety. On 12/3/13 staff added the interventions of monitor skin tear to right elbow, and check on the resident every 1 1/2 - 2 hours overnight to check safety. On 12/8/13 staff updated the care plan and identified the staff replaced the malfunctioning pressure pad alarm on the bed.

Review of the nurse's notes revealed the resident had falls on 6/25/13, 8/27/13, 10/25/13, 10/28/13, 11/7/13, and 12/3/13.

Review of the fall investigations revealed they lacked an analysis of the root cause of the fall in an effort to develop effective interventions to prevent additional falls. Review of 2 falls, on 12/3/13 and 10/28/13 revealed the resident attempted to get out of bed at 1:45 a.m. each time. The investigation revealed at each of those falls, staff identified the last time the resident had toileted was at 10:00 p.m. and 10:30 p.m. Staff failed to investigate why the resident was awake at 1:45 in the morning and attempting to get up. Staff failed to develop new interventions at either of the falls, but identified "alarm sounding" or "alarms already in place."

Observation on 12/12/13 at 10:30 a.m. revealed the resident lay in bed on his/her right side. The bed was flat, and the resident lay with a blanket covering his/her head. The resident lay in a fetal position, with nothing between his/her legs. There was a pressure alarm pad on the resident's wheelchair, and one noted on the bed, with the alarm located on the heating/cooling unit next to the bed. The resident had a fall mat next to the bed, and a sign taped to the wall with the edges curled in, making the sign difficult to read. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 323	Continued From page 62	F 323		

sign stated "Push call light for help".

Observation on 12/12/13 at 10:58 a.m. revealed the resident sat up on the edge of his/her bed. The resident stated that he/she needed to get up and straighten the bed, plus go to the bathroom. The resident had on socks, but not the non-skid socks. The resident's wheelchair remained out of reach of the resident. The resident sat on the edge of the bed and placed his/her feet on the other side of the mat and just sat there. Staff walked in the hallway outside of the room, but did not look in the direction of the room to see the resident.

Observation on 12/12/13 at 11:13 a.m. revealed that Licensed nurse H and direct care staff G took a mechanical lift into the resident's room to assist the resident up from the bed and into the wheelchair.

On 12/16/13 at 6:36 a.m., Licensed nurse X and direct care staff S entered the resident's room and assisted the resident to dress and then used a mechanical lift to have the resident stand and transfer to the wheelchair. As the resident left the bed, the pressure alarm on the bed sounded, and as the staff put the resident in the wheelchair, the pressure alarm in the wheelchair sounded. Prior to the use of the mechanical lift, staff moved a thick fall mat beside the bed so they could get the lift close to the resident as he/she sat in the bed.

On 12/16/13 at 4:52 p.m., direct care staff Q identified the resident as a fall risk. They use alarms on both the bed and wheelchair, as well as a fall mat. Staff Q was not aware of any falls the resident had lately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 323	Continued From page 63	F 323		

On 12/17/13 at 10:42 a.m., direct care staff B said the resident was a fall risk, staff used alarms and a fall mat. Staff B described the resident as very particular and said "If you hear the alarm going off, [he/she] is another one that you had better get there quick."

On 12/17/13 at 2:20 p.m., Administrative nurse A stated the facility determined root cause analysis of falls during the facility's weekly fall meetings. When asked to see that, nurse A stated that the corporation would not allow that because it was protected as part of the facility's QA (Quality Assurance) program. Nurse A was asked to identify the root cause of each of the resident's falls since June 2013 and write it on the back of each of the investigations. Nurse A wrote down the interventions, but did not include root cause analysis.

On 12/17/13 at 3:15 p.m., Administrative nurse N stated the facility's policy directed staff to check on every resident at least every 2 hours. Nurse N said "I understand what you are saying" when told that one of the interventions developed after one of the resident's falls included checking on the resident every 1 1/2 - 2 hours-and how that was not really a new or effective intervention.

The facility failed to determine the root cause of a resident's fall in an effort to ensure the staff provided sufficient supervision or developed effective interventions to prevent additional falls.

- Review of resident #189's physician's review of orders, dated 11/14/13, identified the resident with the diagnosis of weakness.

Review of the admission MDS (Minimum Data

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 323	Continued From page 64	F 323		

Set-a required assessment) dated 11/20/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 9/15, indicating moderately impaired cognition, no indication of depression, did not exhibit behaviors (including rejecting care), required extensive assistance of two staff for bed mobility, transfers, toileting, dependent on one staff for mobility on/off the unit, personal hygiene, with falls in the month prior to admitting to the facility, and with one non-injury fall since admitting to the facility.

Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment-a further assessment) dated 11/25/13 identified the resident had deteriorated in his/her ability to perform ADLs due to a gradual decline at home, personal neglect, and a hospitalization for decubitus wounds, cellulitis, malnutrition, and a fall. The resident had diagnoses of hypertension (HTN), CAD (Coronary Artery Disease) and weakness from an old CVA (stroke). The resident had incontinence of bowel and bladder, as well as a deformity of both upper extremities, which further complicated the resident's ability to perform independent ADLs. The resident required extensive assistance with ADLs, as he/she would stand, but would require two for assistance because of the resident's fear of falling. The resident did not walk (and had not at home for a while), but used a wheelchair for mobility. At the time the resident did not propel the wheelchair with his/her feet, and did not use his/her arms due to the deformity. The CAA identified the resident received PT/OT/ST (Physical Therapy/Occupational Therapy/Speech Therapy) for strengthening, steadiness, transfers, mobility, performing ADLs independently, and eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 323	Continued From page 65	F 323		

Review of the Fall CAA, dated 11/25/13, identified the resident at risk for falls related to his gradual decline at home and personal neglect which resulted in hospitalization for decubitus wounds, cellulitis, altered mental status, severe protein calorie malnutrition, and a fall. The CAA identified the resident had a non-injury fall the first night the resident admitted to the facility when he/she tried to get out of bed and slid down to his/her knees. The CAA identified staff had placed the resident on the facility's fall program with bed and chair alarms and a fall mat next to his/her bed. He/she complained of pain to his/her legs after he/she works with therapies. He/she was working with OT/PT/ST on strengthening, steadiness, transfers, mobility, and performing his/her ADLs.

Review of the temporary care plan, undated, revealed that for mobility, the resident required 2 staff assist with transfers, and on 11/19/13, staff added review of fall 11/13/13. (Facility's fall program). On 11/21/13, staff added re-oriented to facility surrounding, bed and chair alarms.

Review of the resident's fall care plan, dated 11/27/13, identified the resident at risk for falling related to weakness, had memory issues, had a history of falls at home and a non-injury fall at this facility. The care plan directed staff to assure the resident wore his/her eyeglasses and that they are clean and in good repair, give the resident verbal reminders not to ambulate/transfer without assistance, keep call light in reach at all times and remind the resident to use it. The resident sometimes used his/her call light and other times he/she does not. The care plan also directed staff to keep personal items and frequently used items within reach, the resident used a bed and chair alarm, a floor mat, and staff were to keep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 323	Continued From page 66	F 323		

the bed in a low position when the resident was in it. Provide the resident an environment free of clutter, toileting assistance before and after meals and as needed, use a stand pivot maneuver with assist of 1-2 for transfers. On 12/2/13, staff added non-injury fall, and directed staff to be sure to toilet the resident at night.

Review of the nurse's notes revealed the resident experienced falls on 11/13/13 and 12/2/13. Review of the investigations revealed staff failed to determine root cause analysis on why the resident fell. The interventions were a description of what staff had already put in place and included "bed in low position - alarm in place" and "fall mat in place, alarm on chair in place".

Observation on 12/12/13 at 9:45 a.m. revealed the resident sat in a wheelchair in the family room, near the fireplace. Observation revealed a pressure alarm attached to the back of the wheelchair.

On 12/16/13 at 4:52 p.m., Direct care staff Q identified the resident as a fall risk, and stated staff used alarms on both the bed and wheelchair, as well as a fall mat.

On 12/17/13 at 10:42 a.m., Direct care staff B stated the resident was a fall risk, and staff used alarms and a fall mat to keep the resident safe. Staff B stated "If you don't come running to [him/her] when [he/she] starts to holler, [he/she] will try to get up and walk."

On 12/17/13 at 12:30 p.m., Administrative nurse O and Administrative nurse P both stated that interventions are immediately developed by the charge nurse on duty at the time of the fall and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 323	Continued From page 67	F 323		

put that in the fall investigation. The next day, the staff get together during stand up and they discuss the intervention that was put in place and make sure all staff are following the new interventions. Then, once a week, they have a fall committee meeting and it is at that meeting that they do a root cause analysis and determine that the investigation(s) put in place address the cause and staff are still doing them.

On 12/17/13 at 1:30 p.m. Administrative Nurse A, stated that the root cause analysis was done during the weekly Fall Committee meeting. Nurse A stated that he/she could not provide the page where the staff analyzed the fall because the form was considered part of their QA (Quality Assurance) program, but he/she would write the analysis on the back of the investigation. Nurse A failed to identify root cause analysis of the falls.

Review of the facility's policy on Fall Management revealed the following guidance to staff:
"Fall Committee meetings will be held weekly. During the Fall Committee meetings the Post Fall Investigation and incident report will be reviewed for each fall since the prior meeting.
The Fall Reduction Tracking is completed by reading the list of interventions, selecting the appropriate ones, writing the date the interventions was used, the initials of who is completing the form, and any follow up needed or comments."

The facility failed to have a program that directed staff to determine root causes analysis of each fall to ensure that staff developed and implemented appropriate interventions to prevent additional falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 325	Continued From page 68	F 325		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 72 residents with 23 included in the sample. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for nutrition received with a planned nutritional supplement. (#198)

Findings included:

- Review of resident #198's signed physician orders dated 12/4/13 revealed the resident had a diagnosis of lung cancer. The resident admitted to the facility on 12/3/13.

Review of an Admission Nursing Evaluation dated 12/3/13 revealed the resident required supervision of one staff for eating, assist of one for transfers and walking. The resident had a controlled carbohydrate regular diet with thin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 325	Continued From page 69	F 325		

liquids. The resident did not have teeth and had several food dislikes.

Review of the resident ' s temporary care plan initiated 12/3/13, revealed the resident fed him/herself, did not have dentures, and was a diabetic. An entry added on 12/4/13 revealed the resident received a regular diet with a house nutritional supplement three times a day (TID).

Review of the resident's laboratory values on 12/3/13 revealed the resident had an albumin (a blood test used to measure the amount of protein in the blood and is used in part to determine a person's nutrititional status) level of 2.3 g/dL (micrograms/deciliter) with the normal range of 3.5 g/dL-4.8 g/dL, indicating inadequate protein and caloric intake by the resident.

Review of a interdisciplinary progress note dated 12/3/13 revealed the resident had a controlled carbohydrate diet of 1600-2100 calories a day with Ensure high protein with breakfast and lunch. The resident received a regular thin diet and dietary was informed of the resident's diet.

Review of a physician order on 12/4/13 revealed staff were to increase the resident's house nutritional supplement to TID. The telephone order had been check marked as documented in the nurses notes, but the documentation for the medication sheet and care plan had not been checked.

Review of a Dietary Risk Review dated 12/4/13 revealed the resident took megastrol (Megace), an appetite stimulant medication, and received the house nutritional supplement BID, the resident had no teeth, and ate independently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 325	Continued From page 70	F 325		

Review of a Nutritional Risk Review dated 12/4/13 revealed the resident's current body weight was 140 lbs (pounds) which was 90% (percent) of the resident's ideal body weight. The resident received a controlled carbohydrate diet with a nutritional supplement twice a day and received Megace. The resident had a diagnosis of non-small cell lung cancer and per a hospital note was currently undergoing chemotherapy. Weight changes may be unavoidable due to cancer diagnosis. Recommendations included changing the nutritional supplement to TID and following weekly weights and oral intake.

Review of the resident's weights revealed: 12/3/13 was 140 lbs, 12/4/13 was 138.08 lbs, 12/5/13 was 138.12 lbs, and 12/6/13 was 138.12 lbs.

Review of the December 2013 (through 12/16/13) Meal Intake Record revealed the resident ate 100% for 29 meals, 80% for 3 meals, 60% for 3 meals, 30% for 2 meals, 20% for 2 meals, and had refused one meal.

Review of the medication administration record (MAR) for 12/3/13-12/12/13 revealed staff did not document the percentage consumed of the resident's Ensure High Protein BID. For 12/13/13-12/16/13 staff documented intake of the Ensure for each day except 12/15/13 when no intake was documented.

Review of a physician order sheet dated 12/13/13 revealed an order for Ensure High Protein (a nutritional supplement) twice a day (BID).

Observation on 12/12/13 at 12:48 p.m. revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 325	Continued From page 71	F 325		

the resident had eaten 100% of his/her meal comprised of turkey potpie, cooked spinach, spiced pears, and a dinner roll. The resident drank a glass of water and a glass of soda.

Observation on 12/16/13 at 8:10 a.m. revealed the resident sat at the dining room table and was served a cup of coffee, a glass of water, and two pancakes with butter and syrup. The resident ate 100% of his/her meal.

Observation on 12/16/13 at 11:52 a.m. revealed direct care staff member LL came to the kitchen, told the cook the resident was not coming out for lunch but had asked for a a Gatorade and an Ensure. Staff took them to the resident. At 12:30 p.m., observation revealed the resident had consumed the Ensure.

Observation on 12/17/13 at 8:30 a.m. revealed the resident was served two sausage patties, two fried eggs, coffee, and water. The resident ate 100% of the meal.

Interview with the resident on 12/17/13 at 12:05 p.m. revealed he/she received the Ensure if he/she asked for it, but the staff did not bring it in unless he/she asked for it. The resident reported he/she had just drank an Ensure and he/she liked them and would drink them if staff brought them to him. The resident reported his/her doctor told him/her to drink them, so he/she tried to be sure he/she drank them. The resident reported he/she had lost weight due to his/her cancer diagnosis and not having a very good appetite and had lost almost 50 lbs since July.

Interview with direct care staff LL on 12/16/13 at 1:52 p.m. revealed he/she was not sure about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 325	Continued From page 72 how the resident's appetite was and reported the resident asked for Ensure and Gatorade at lunch. Staff reported the resident did drink the Ensure when staff took it to him/her and reported the nurse documented the supplement intake. Staff reported he/she would assume the resident was at risk for weight loss. Interview with licensed nursing staff KK on 12/11/2013 12:17 p.m. revealed the resident received Ensure high protein BID and drank all of it most of the time. Staff confirmed the amount the resident consumed was not documented in the MAR and should be. Staff reported the initials on the MAR only meant the resident received it. Interview on 12/17/13 at 10:49 a.m. with licensed nursing staff W revealed when a resident received a nutritional supplement, the nurse documented when they gave it and the percentage the resident consumed. Interview on 12/17/13 at 1:01 p.m. with administrative nursing staff A revealed he/she expected staff to document supplements on the MAR that it was given, but reported staff were not expected to document the percentage the resident consumed. The facility failed to ensure the resident received a nutritional supplement as ordered.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 329	Continued From page 73	F 329		

without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 72 residents with 23 residents sampled. Of those, 5 residents were reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to identify and monitor specific behaviors related to medications for 3 of 5 residents. (#193, #50, and #39)

Findings included:

- Review of resident #193's physician order sheet dated 11-21-13 revealed a diagnosis of anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 329	Continued From page 74	F 329		

characterized by exaggerated feelings of sadness, worthlessness and emptiness), and insomnia (inability to sleep).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 11-27-13 revealed a BIMS (Brief Interview for mental Status) score of 13 indicating cognitively intact. The MDS also revealed a score of 5 on the mood scale indicating mild depression. The MDS identified the resident had no behavioral symptoms and had current diagnoses of anxiety disorder and depression. It also identified the resident received an antianxiety medication 6 out of 7 days, an antidepressant 7 out of 7 days, and a hypnotic 2 out of the past 7 days.

Review of the psychotropic medication CAA (Care Area Assessment) dated 12-3-13 revealed an analysis of findings that the resident received Restoril (a hypnotic sleeping medication) for insomnia, Zoloft (an antidepressant) and Xanax (Alprazolam, an antianxiety medication) for depression with anxiety.

Review of the care plan dated 12-4-13 identified the resident received an antidepressant medications with interventions to assess/record effectiveness of drug treatment, monitor for side effects, monitor resident mood and response to medications, and consult pharmacy. The care plan failed to identify specific targeted symptoms for the staff to monitor.

The care plan also identified the resident received an antianxiety medication related to depression with anxiety and directed staff to monitor for drug use effectiveness and adverse consequences, quantitatively and objectively document the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 329	Continued From page 75	F 329		

resident's behavior/mood. It failed to specifically identify targeted behavior for staff to monitor and failed to direct staff on non-pharmacological interventions to use prior to administering the medication.

The same care plan identified the resident received a hypnotic medication related to insomnia and anxiety and directed staff to assess/record effectiveness of drug treatment, monitor and report adverse side effects. It also directed staff to attempt non-pharmacological interventions such as repositioning, toileting the resident and offering the resident a drink or snack. The care plan failed to identify specific interventions the resident used at home to help with sleeping.

Review of the Physicians order sheet revealed the resident had the following orders: Zoloft (an antidepressant) 100 mg (milligram) 1.5 tablets daily for depression, Xanax (an antianxiety medication) 0.25 mg. tablet daily as needed for anxiety, and Restoril (a hypnotic) 30 mg 1 capsule at bed time as needed for insomnia.

Review of the (MAR) Medication administration Record from 11-20-13 to 12-13-13 revealed the resident received 17 doses of Xanax. The documentation on the back of the MAR identified each time it was administered it was for increased anxiety but did not identify any specific behavior the resident had. The MAR also identified the resident received 6 doses of Restoril and was only written on the back of the MAR for administration twice and the results documented were " resting " both times. The MAR lacked any documentation for administration or follow up of the other 4 doses, or what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 329	Continued From page 76	F 329		

non-pharmacological interventions staff attempted prior to giving the medications.

Review of the Behavior Risk Assessment dated 11-20-13 had all zeros documented indicating the resident did not have any behaviors. It also identified the resident was alert and oriented to person, place, and time with no behaviors noted.

Review of the medical record also lacked any documentation regarding specific targeted behaviors the staff monitored to assess the effectiveness of the antianxiety, antidepressant, or the hypnotic medications.

On 12-16-13 at 12:42 p.m. direct care staff S stated the aides did not document any behaviors. He/she stated the nurse aides were to tell the nurse of any changes or things out of the ordinary. Staff S gave examples of dizziness, weakness, pain, not acting themselves, any bruising, skin tears, or anything like that.

On 12-17-13 at 10:06 a.m. direct care staff B stated the resident did not have any behaviors.

On 12-17-13 direct care staff GG stated if the resident wanted a prn (as needed) medication such as something for anxiety or pain, the nurse had to assess the resident regarding their request and then would instruct the medication aide what medication to administer. The nurse would then go back and assess the resident in about an hour to see how well the medication worked and the nurse would tell the medication aide what to write on the back. Staff GG reported the person who administered the medication needed to document on the back of the MAR what the medication was, dose, time given, reason given and the results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 329	Continued From page 77 On 12-17-13 at 12:12 p.m. licensed nursing staff Y stated that the nurse documented on the behavior sheet, on the daily skilled nursing note, or in the interdisciplinary notes if it was a long term care resident. Staff Y also stated if the resident did not have any behaviors there would not be anything documented in the nurses notes. On 12-17-13 at 10:41 a.m. administrative nursing staff FF stated that any time a resident had an order for an antianxiety, or psychotropic medication the resident should have a behavior sheet so staff could document. On 12-16-13 at 12:16 p.m. administrative nursing staff P stated the charge nurse was responsible for initiating behavior monitoring sheets. He/she also stated the facility did not do any kind of sleep assessment that would identify what the resident did at home to help them sleep or things they would like for the facility staff to do. On 12-17-13 at 10:54 a.m. administrative nursing staff A stated if a resident received any type of psychotropic medication the facility needed to be monitoring to justify the reason for the medication. He/she stated the expectation was for staff to do behavior monitoring documentation on behavior sheets as well as following up for effectiveness of any as needed medications administered. Review of the undated behavior policy revealed the facility would monitor residents for behavioral issues and provide the necessary treatment and services for the management of those behavioral issues.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 329	Continued From page 78	F 329		

The facility failed to identify the specific behavioral issues for a resident who received psychotropic medications.

- Review of resident #50's physician order sheet dated 11-10-13 included diagnosis of agitation, dementia with agitation (Dementia- progressive mental disorder characterized by failing memory, confusion), and nonorganic psychosis (any major mental disorder characterized by a gross impairment in reality testing).

Review of the annual MDS (Minimum Data Set 3.0, a required assessment) dated 4-19-13 revealed a BIMS (Brief Interview for Mental Status) score of 8 indicating moderate cognitive impairment. The MDS identified the resident had symptoms of delirium such as; inattention, disorganized thinking, and altered level of consciousness. These symptoms fluctuated in frequency and severity. The resident had a mood score of 0 indicating no symptoms of depression. The MDS identified the resident current diagnoses of depression and had a psychotic disorder. It also identified the resident received an antipsychotic and antidepressant medication 7 out of the past 7 days.

Review of the quarterly MDS dated 10-20-13 revealed BIMS score of 8 indicating moderate cognitive impairment. The MDS also identified the resident had delusions but no other behaviors. It included current diagnoses of dementia, depression, and psychotic disorder. It also revealed the resident received an antipsychotic and antidepressant medication 7 out of the past 7 days.

Review of the Psychotropic medication CAA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 329	Continued From page 79	F 329		

(Care Area Assessment) dated 4-23-13 identified the resident at risk for adverse effects from taking psychotropic medications. It identified the resident received an antidepressant and antipsychotic medication that were not new for the resident. It identified the pharmacist reviewed the residents medications quarterly and made recommendations to the physician accordingly, and nursing staff kept track of any behaviors the resident had. The CAA did not identify the behaviors the resident might have.

Review of the care plan last reviewed on 10-31-13 revealed the resident received an antidepressant medication and an antipsychotic medication. The care plan directed staff to monitor and report signs of sedation and or extrapyramidal symptoms (movement disorders as a result of taking certain medications). Staff was to monitor the resident's behavior and response to medication, pharmacy consultant review quarterly, assess/record effectiveness of medication, monitor for adverse side effects, and attempt non-pharmacological interventions. The care plan did not identify what behaviors to monitor for staff to evaluate effectiveness of medication and did not identify non-pharmacological interventions to try.

Review of the MARs (Medication Administration Record) for November and December 2013 revealed the resident received the following medications: Risperdone (an antipsychotic) 0.5 mg. (milligram) 2 tablets (total of 1 mg.) every a.m. for dementia with behaviors/agitation, Remeron (an antidepressant) 30 mg. 1 tablet at bedtime for depression, and Risperdone 0.5 mg at bedtime for agitation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 329	Continued From page 80	F 329		

Review of the Behavior Risk Assessment initiated on 10-1-13 revealed the resident did not have any behaviors

Review of the behavior monitoring notebook revealed the resident did not have a behavior monitoring sheet.

On 12-16-13 from 11:57 a.m. to 12:32 p.m. observation revealed the resident sat in high back wheelchair with spouse. The resident sat very quietly, while spouse assisted him/her to eat the noon meal and did not express any signs of agitation or depression.

On 12-16-13 at 12:42 p.m. direct care staff S stated the aides did not document any behaviors. He/she stated the nurse aides were to tell the nurse of any changes or things out of the ordinary. Staff S gave examples of dizziness, weakness, pain, not acting themselves, any bruising, skin tears, or anything like that.

On 12-17-13 at 10:01 a.m. direct care staff DD the aides did not document behaviors but were to report anything out of the ordinary to the charge nurse. Staff DD stated the resident would sometimes yell out and could get aggressive/combative with staff during care.

On 12-17-13 at 10:30 a.m. licensed nursing staff EE stated that resident behaviors are monitored and there is a behavior book that had the behavior sheets in them for the nurse to fill out. Staff EE stated the behavior sheets were for is anyone received a psychotropic medications otherwise the nurse documented it in the nurse's notes. He/she stated the resident did not like to take medications and did not always open his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

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F 329	Continued From page 81	F 329		

mouth to eat well.

On 12-17-13 at 10:41 a.m. administrative nursing staff FF stated that any time a resident had an order for an antianxiety, or psychotropic medication the resident should have a behavior sheet so staff could document if the resident had a behavior or not.

On 12-17-13 at 10:54 a.m. administrative nursing staff A stated if a resident received any type of psychotropic medication the facility needed to be monitoring to justify the reason for the medication. He/she stated the expectation was for staff to do behavior monitoring documentation on behavior sheets as well as following up for effectiveness of any as needed medications administered.

Review of the undated behavior policy revealed the facility would monitor residents for behavioral issues and provide the necessary treatment and services for the management of those behavioral issues.

The facility failed to identify the specific behavioral issues for a resident who received psychotropic medications.

- Review of resident #19's review of physician orders, signed by the physician as 12/13, identified the resident with the diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).

Review of the significant change MDS (Minimum Data Set-a required assessment) dated 10/30/13, identified the resident with a BIMS (Brief Interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 329	Continued From page 82	F 329		

for Mental Status) score of 4/15 (indicating severely impaired cognition), rejected care 1-3 days of the 7 day assessment, and received 7 days of antipsychotic, antidepressant, and antianxiety medications in the 7 day look back period.

Review of the Psychotropic Medication CAA (Care Area Assessment-a further assessment) dated 11/13/13, revealed the resident received Cymbalta (an antidepressant) for depression and Valium (an anti-anxiety) for anxiety, was recently started on Risperdal (an anti-psychotic) for psychosis with delusions. Pharmacy consultant reviews medications monthly for GDR (Gradual Dose Reduction) if appropriate.

Review of the Psychotropic Medication Care plan, dated 11/15/13, revealed the following:
Cymbalta for depressive symptoms: Black box warning for clinical worsening and suicide risk: Monitor blood pressure WORSENING OF DEPRESSION AND/OR SUICIDAL BEHAVIOR OR THINKING. It then included a long list of potential side effects.
Diazepam (general form of Valium) for anxiety disorder: Monitor blood pressure, and included a long list of potential side effects.
Divalproex Sodium for mood stabilization. Black box warning for hepatotoxicity (liver toxicity) and pancreatitis (inflammation of the pancreas). It then included a long list of potential side effects.
Risperidone for schizophrenia/behavioral symptoms associated with dementia in elderly: Black box warning for increased mortality in elderly patients with dementia related psychosis. It then identified a long list of potential side effects.
Zolpidem, for sleep enhancement: Monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 83	F 329		

"next-day" impairment & drowsiness, as well as a long list of potential side effects.
The care plan lacked specific, targeted behaviors for staff to monitor to ensure the medications' effectiveness.

Review of the resident's December 2013 MAR (Medication Administration Record) revealed the staff administered the following medications to the resident:
Cymbalta 60 mg (milligrams) daily for depression
Diazepam 2 mg every 8 hours for anxiety
Risperdal 0.25 mg 1/2 tab (0.125 mg) daily at bedtime for psychosis

Review of the CNA (Certified Nurse's Aide) Communication Walking Rounds dated 10/18/13-12/15/13 revealed the resident had confusion 11 times, trying to get out of bed on his/her own 9 times, crying/yelling out twice, and being fussy once.

Review of the behavioral monitoring book on 12/17/13 at 12:04 p.m. revealed there were no behavioral monitoring sheets for the resident.

Observation on 12/12/13 at 11:13 a.m. revealed that Licensed nurse H and direct care staff G took a mechanical lift into the resident's room to assist the resident up from the bed and into the wheelchair. The resident communicated with the staff in a pleasant manner, and did not exhibit behaviors, but was cooperative with staff.

Interview with direct care staff B on 12/17/13 at 11:58 a.m. revealed the direct care staff did not chart on any resident behaviors, the nurse did based off of his/her observations or what the staff tell him/her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 329	Continued From page 84 Interview with Licensed nurse Y on 12/17/13 at 12:03 p.m. revealed the nurses were responsible for charting behaviors in the behavioral monitoring book if the resident had behaviors or took an "as needed" medication that required monitoring. Staff reported there were not any residents that required behavioral monitoring in that house at this time. On 12/17/13 at 12:30 p.m., administrative nurse O and administrative nurse P identified they were responsible for developing the care plans. Staff P stated they do not identify specific targeted behaviors for the residents on antipsychotic medications. They said that the staff are supposed to be monitoring behaviors in a behavior monitoring book, but the behaviors are general and not specific. They do not put specific targeted behaviors on the care plan so staff know what to monitor for. Review of the facility's undated policy on Behaviors identified nursing staff would document any behaviors in the caretracker system. The policy failed to direct staff to identify specific, targeted behaviors for each psychoactive medication and to provide routine monitoring and analysis of the monitoring to ensure the continued necessity of the psychoactive medications. The facility failed to identify specific, targeted behaviors for each psychoactive medication for a resident. The staff also failed to monitor the resident's behaviors to ensure the effectiveness of the psychoactive medications.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 353	Continued From page 85 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility census totaled 72 residents. Based on observation and interview the facility failed to have sufficient staff to provide necessary care and services, including supervision, to ensure resident needs as care planned were met. This had the potential to affect all residents in the facility. Findings included: - During stage 1 of the survey 8 of 21 residents interviewed expressed concerns with a lack of staff and 2 of 3 family members also voiced	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 353	Continued From page 86	F 353		

concerns regarding a lack of sufficient staff.

On 12-16-13 at 8:48 a.m. observation revealed a resident on 100 hall was calling out for help. Observation revealed the resident was lying in his/her bed with a hospital gown on, partially uncovered, wheelchair was in reach, and the call light was tied to the bed rail which was in the down position out of the residents reach. The resident reported he/she needed assistance to go to the bathroom, no staff was in the area to hear the resident or in sight and the nurse was passing medications. The nurse told the nursing assistant to go and help the resident and he/she did. The nursing assistant came out of the room a short time later with a visibly urine soaked brief inside a clear plastic bag.

On 12-16-13 at 9:13 a.m. direct care staff RR and direct care staff PP stated the residents required a lot of assistance and sometimes took 2 staff. They stated there is not enough staff to meet all the needs of the residents especially in the mornings when they need to be out for breakfast, some resident's want showers in the morning before breakfast and some residents require the use of a mechanical lift which takes 2 staff to use.

On 12-16-13 at 9:14 a.m. direct care staff M stated that normally there were 2 aides, 1 nurse, and medication aide but the med aide did not usually come in until 10:00 in the morning. Staff M stated that 2 aides were just not enough to take care of all 18 residents.

On 12-16-13 at 1:52 p.m. direct care staff LL reported there was only two nurse aides on day shift and did not feel there was enough staff in the house for first shift. Staff LL stated not everything

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 353	Continued From page 87	F 353		

got done because there was not enough time, for example, not everyone got their teeth brushed in the mornings.

On 12-16-13 at 4:56 p.m. licensed nursing staff KK reported that when there was a medication aide, then he/she could get his/her job done. When there is not a medication aide he/she also had to pass medications. Staff KK stated it all depended on the acuity of the residents as to whether they had enough staff or not. Staff KK stated, " When we have to double up our speed, we miss some things and the resident misses out on some cares " .

On 12/16/13 at 6:22 a.m., licensed nursing staff TT on night shift stated there was usually one nurse and one aide for each house. Staff TT stated he/she had reported the need for more staff to administration but did not actually get any. He/she stated administration did look into having nurse aides from one house float and help the other house. He/she said they even talked about moving residents to adjust the work load between houses.

Interview on 12-16-13 at 4:48 PM licensed nurse staff FF reported he/she monitored staff and made sure they were toileting, turning and providing necessary cares for the residents on unit by walking rounds. Staff FF stated he/she visited each resident room once a day.

On 12-17-13 at 2:29 p.m. administrative nursing staff A stated staff is generally so many staff per number of residents. Staff A stated if one house had higher acuity they would bring in additional staff to help provide care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 353	Continued From page 88 The facility failed to provide sufficient staff to ensure timely repositioning of 1 of 1 resident at risk for pressure ulcers, see F-314 for further details. The facility failed to provide sufficient staff to ensure adequate personal hygiene was completed for 3 residents regarding dental care, facial hair trimming and nail care, See F-312 for further details. The facility failed to provide adequate supervision to ensure adequate catheter care was being done to prevent Urinary Tract Infections for 2 residents, see F-315. The facility failed to provide adequate supervision to ensure staff treated residents with dignity, see F-241 for details. The facility failed to provide adequate supervision to ensure staff provided resident care using proper infection control techniques and standards of care, see F-441 for details. The facility failed to provide adequate staff and supervision to ensure that residents were provided necessary care and services needed to meet their care as planned.	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 364	Continued From page 89 This REQUIREMENT is not met as evidenced by: The facility had a census of 72 residents with 18 resident residing in Angela Joseph hall. Based on observation, recored review and interview the facility failed to maintain the proper holding food temperatures for food available to be served to the residents which had potential to affect 17 of the 18 residents. Findings included: - Observation on 12-16-13 at 1:10 PM revealed the holding food temperatures of the food in the kitchen steam table available for service to the residents were pork tenderloin 108 degrees, sweet potatoes 107degrees, mixed viegetables 99 degrees. During an interview on 12-16-13 at 1:15 PM dietary staff E revealed the service temperature of the food should be at least 115 degrees. Review of the facility food policy (undated) revealed the temperature of hot food items should be above 140 degrees, if they are less than that, they must be returned for heating. The facility failed to maintain the safe, proper food temperatures for food available to the residents to consume.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 371	Continued From page 90 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility census included 72 residents. Based on observation and interview, the facility failed to ensure dietary staff effectively used hair restraints in 3 of 4 kitchens and to ensure the resident's were not served contaminated food. Findings included: - Observation on 12/10/13 at 12:10 p.m. revealed dietary staff D served food from kitchen 4 with a hair net partially covering his/her hair. The back portion of the staff member's hair at the base of his/her head remained uncovered. Observation on 12/10/13 at 12:22 p.m. revealed in kitchen 3, dietary staff MM served food from the kitchen with the roots of his/her hair only partially covered with a hair net. The hair around the ears and at the base of the neck remained uncovered. Observation on 12/16/13 at 11:40 a.m. revealed dietary staff F cleaned a temperature probe with a cleaner wipe, then blew on it to dry it. Staff F then used the same temperature probe and put it in the cooked yams just before serving. Interview on 12/16/13 at 12:32 p.m. with dietary staff E, revealed everyone had to wear hair	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 371	Continued From page 91 restraints when entering the kitchen. Staff E expected staff to wear beard covers for anything over eyelash length. Review of the undated facility policy for Personnel Sanitizations Standards revealed dietary personnel were required to wear a hair restraint at all times while on duty. The undated facility policy for food temperatures lacked information about cleaning the temperature probe when obtaining food temperatures. The facility failed to ensure dietary staff effectively restrained their hair while in the kitchen and served uncontaminated food. - On 12-16-15 at 10:20 am. dietary staff BB, who had a beard and mustache, prepared sweet potatoes for the noon meal without wearing a mustache or beard cover. On 12-16-13 at 12:06 p.m. dietary staff BB plated food for the residents who lived in the 200 house without wearing a beard/mustache covering. On 12-17-13 at 2:59 p.m. dietary staff E stated the policy regarding hair restraints directed staff to cover all facial hair. The facility failed to ensure staff restrained facial hair to maintain sanitary conditions for food preparation and serving.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 92	F 428		

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 72 residents. The sample included the review of the medication regimen of 5 residents. Based on observation, interview and record review, the pharmacist failed to identify the facility's lack of a program that ensured staff identified targeted behaviors for each psychoactive medication and monitored the effectiveness to ensure the continued necessity of each psychoactive medication for 3 of 5 sampled residents. (#19, #50, and #193)

Findings included:

- Review of resident #19's review of physician orders, signed by the physician as 12/13, identified the resident with the diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).

Review of the significant change MDS (Minimum Data Set-a required assessment) dated 10/30/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 4/15 (indicating severely impaired cognition), rejected care 1-3 days of the 7 day assessment, and received 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 428	Continued From page 93	F 428		

days of antipsychotic, antidepressant, and antianxiety medications in the 7 day look back period.

Review of the Psychotropic Medication CAA (Care Area Assessment-a further assessment) dated 11/13/13, revealed the resident received Cymbalta (an antidepressant) for depression and Valium (an anti-anxiety) for anxiety, was recently started on Risperdal (an anti-psychotic) for psychosis with delusions. Pharmacy consultant reviews medications monthly for GDR (Gradual Dose Reduction) if appropriate.

Review of the Psychotropic Medication Care plan, dated 11/15/13, revealed it contained the black box warnings associated with each of the psychoactive medications the resident had physician's orders for, but lacked specific, targeted behaviors for each of the medications.

Review of the resident's December 2013 MAR (Medication Administration Record) revealed the staff administered the following medications to the resident:
Cymbalta 60 mg (milligrams) daily for depression
Diazepam 2 mg every 8 hours for anxiety
Risperdal 0.25 mg 1/2 tab (0.125 mg) daily at bedtime for psychosis

Review of the CNA (Certified Nurse's Aide) Communication Walking Rounds dated 10/18/13-12/15/13 revealed the resident had confusion 11 times, trying to get out of bed on his/her own 9 times, crying/yelling out twice, and being fussy once.

Review of the behavioral monitoring book on 12/17/13 at 12:04 p.m. revealed there were no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 94	F 428		

behavioral monitoring sheets for the resident.

Review of the pharmacist's monthly reviews revealed the reviews lacked any mention of the need for targeted behaviors, or a lack of behavior monitoring by the staff.

Observation on 12/12/13 at 11:13 a.m. revealed that Licensed nurse H and direct care staff G took a mechanical lift into the resident's room to assist the resident up from the bed and into the wheelchair. The resident communicated with the staff in a pleasant manner, and did not exhibit behaviors, but was cooperative with staff.

Interview with Licensed nurse Y on 12/17/13 at 12:03 p.m. revealed the nurses were responsible for charting behaviors in the behavioral monitoring book if the resident had behaviors or took an "as needed" medication that required monitoring. Staff reported there were not any residents that required behavioral monitoring in that house at this time.

On 12/18/13 at 2:38 p.m., LIcensed Pharmacist QQ identified that he/she did not look for specific, targeted behaviors for each psychoactive medication. Pharmacist QQ identified that he/she looked in the nurse's notes for documentation of behaviors. When asked if he/she determined if the facility analyzed the behaviors month to month to determine if the psychoactive medications remained necessary, Pharmacist QQ identified he/she thought that happened with the MDS process.

Review of the facility's undated policy on Behaviors identified nursing staff would document any behaviors in the caretracker system. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 95	F 428		

policy failed to direct staff to identify specific, targeted behaviors for each psychoactive medication and to provide routine monitoring and analysis of the monitoring to ensure the continued necessity of the psychoactive medications.

The pharmacist failed to identify the irregularity of the lack of specific, targeted behaviors and behavior monitoring or each psychoactive medication for a resident.

- Review of resident #193's physician order sheet dated 11-21-13 revealed a diagnosis of anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and insomnia (inability to sleep).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 11-27-13 revealed a BIMS (Brief Interview for mental Status) score of 13 indicating cognitively intact. The MDS identified the resident had no behavioral symptoms and received an antianxiety medication 6 out of 7 days, an antidepressant 7 out of 7 days, and a hypnotic 2 out of the past 7 days.

Review of the psychotropic medication CAA (Care Area Assessment) dated 12-3-13 revealed an analysis of findings that the resident received restoril (a hypnotic) for insomnia, zoloft (an antidepressant), and xanax (an antianxiety) for depression with anxiety.

Review of the care plan dated 12-4-13 for psychotropic medications directed staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 96	F 428		

assess/record effectiveness of drug treatment, monitor for side effects, monitor resident mood and response to medications, and consult pharmacy. The care plan failed to identify specific targeted symptoms for staff to monitor for each psychotropic medication.

Review of the (MAR) Medication administration Record from 11-20-13 to 12-13-13 revealed the resident received 17 doses of Xanax. The documentation on the back of the MAR identified each time it was administered it was for increased anxiety but did not identify any specific behavior the resident had. The MAR also identified the resident received 6 doses of Restoril and was only written on the back of the MAR for administration twice and the results documented were "resting" both times. The MAR lacked any documentation for administration or follow up of the other 4 doses.

Review of the medical record also lacked any documentation regarding specific targeted behaviors the staff monitored to assess the effectiveness of the antianxiety, antidepressant, or the hypnotic medications.

Review of the pharmacy review completed on 11-25-13 failed to identify the lack of a specific behavior and the lack of behavior monitoring.

On 12-16-13 at 12:42 p.m. direct care staff S stated the aides did not document any behaviors. He/she stated the nurse aides were to tell the nurse of any changes or things out of the ordinary. Staff S gave examples of dizziness, weakness, pain, not acting themselves, any bruising, skin tears, or anything like that.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 97	F 428		

On 12-17-13 direct care staff GG stated if the resident wanted a prn (as needed) medication such as something for anxiety or pain, the nurse had to assess the resident regarding their request and then would instruct the medication aide what medication to administer. The nurse would then go back and assess the resident in about an hour to see how well the medication worked and the nurse would tell the medication aide what to write on the back. Staff GG reported the person who administered the medication needed to document on the back of the MAR what the medication was, dose, time given, reason given and the results.

On 12-17-13 at 12:12 p.m. licensed nursing staff Y stated that the nurse documented on the behavior sheet, on the daily skilled nursing note, or in the interdisciplinary notes if it was a long term care resident. Staff Y also stated if the resident did not have any behaviors there would not be anything documented in the nurses notes.

On 12-16-13 at 12:16 p.m. administrative nursing staff P stated the facility did not do any kind of sleep assessment that would identify what the resident did at home to help them sleep or things they would like for the facility staff to do prior to the administration of hypnotic medication.

On 12-18-13 at 2:38 p.m. consultant pharmacist staff QQ reported he/she did not monitor to see if the facility identified specific targeted behaviors related to psychoactive medications and as far as monitoring of behaviors it was his/her understanding that was in the nurses notes.

Review of the undated behavior policy revealed the facility would monitor residents for behavioral issues and provide the necessary treatment and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 98	F 428		

services for the management of those behavioral issues.

The consulting pharmacist failed to identify the facility's failure to monitor specific, targeted behaviors related to medication use.

- Review of resident #50's physician order sheet dated 11-10-13 included diagnosis of agitation, dementia with agitation (Dementia- progressive mental disorder characterized by failing memory, confusion), and nonorganic psychosis (any major mental disorder characterized by a gross impairment in reality testing).

Review of the quarterly MDS dated 10-20-13 revealed BIMS score of 8 indicating moderate cognitive impairment. The MDS also identified the resident had delusions but no other behaviors. It included current diagnoses of dementia, depression, and psychotic disorder. It also revealed the resident received an antipsychotic and antidepressant medication 7 out of the past 7 days.

Review of the Psychotropic medication CAA (Care Area Assessment) dated 4-23-13 identified the resident at risk for adverse effects from taking psychotropic medications. It identified the resident received an antidepressant and antipsychotic medication that were not new for the resident. It identified the pharmacist reviewed the residents medications quarterly and made recommendations to the physician accordingly, and nursing staff kept track of any behaviors the resident had. The CAA did not identify the behaviors the resident might have.

Review of the care plan last reviewed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 99	F 428		

10-31-13 revealed the resident received an antidepressant medication and an antipsychotic medication. The care plan directed staff to monitor and report signs of sedation and or extrapyramidal symptoms (movement disorders as a result of taking certain medications). Staff was to monitor the resident's behavior and response to medication, pharmacy consultant review quarterly, assess/record effectiveness of medication, monitor for adverse side effects, and attempt non-pharmacological interventions. The care plan did not identify what behaviors to monitor for staff to evaluate effectiveness of medication and did not identify non-pharmacological interventions to try.

Review of the behavior monitoring notebook revealed the facility failed to initiate a behavior monitoring sheet for the resident.

Review of the monthly pharmacy reviews revealed lacked mention of the failure to identify targeted behaviors for psychotropic medications and the need to monitor those behaviors.

On 12-16-13 from 11:57 a.m. to 12:32 p.m. the resident sat in high back wheelchair with family member. The resident sat very quietly, while family member assisted him/her to eat the noon meal and did not express any signs of agitation or depression.

On 12-17-13 at 10:01 a.m. direct care staff DD the aides did not document behaviors but were to report anything out of the ordinary to the charge nurse. Staff DD stated the resident would sometimes yell out and could get aggressive/combative with staff during care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 428	Continued From page 100 On 12-17-13 at 10:30 a.m. licensed nursing staff EE stated that resident behaviors are monitored and there is a behavior book that had the behavior sheets in them for the nurse to fill out. Staff EE stated the behavior sheets were for is anyone received a psychotropic medications otherwise the nurse documented it in the nurse's notes. He/she stated the resident did not like to take medications and did not always open his/her mouth to eat well. On 12-17-13 at 10:41 a.m. administrative nursing staff FF stated that any time a resident had an order for an antianxiety, or psychotropic medication the resident should have a behavior sheet so staff could document if the resident had a behavior or not. On 12-18-13 at 2:38 p.m. consultant pharmacist staff QQ reported he/she did not monitor to see if the facility identified specific targeted behaviors related to psychoactive medications and as far as monitoring of behaviors it was his/her understanding that was in the nurses notes. Review of the undated behavior policy revealed the facility would monitor residents for behavioral issues and provide the necessary treatment and services for the management of those behavioral issues. The consulting pharmacist failed to identify the facility's failure to monitor specific, targeted behaviors related to medication use.	F 428		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 431	Continued From page 101	F 431		

a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
The facility census included 72 residents. Based on observation, record review, and interview, the facility failed to have a pharmaceutical system for labeling medications and discarding expired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 431	Continued From page 102	F 431		

medications. This failure had the potential to affect all residents residing in the facility.

Findings included:

- Observation on 12/10/13 at 10:45 a.m. revealed a vial of Levemir insulin in the medication room refrigerator in house 4 with a discard date of 12/1/13, a Humalog insulin pen not marked with an open or discard date, and a NovoLog insulin pen with a discard date of 12/7/13.

Interview with licensed nursing staff Y on 12/10/13 at 10:45 a.m. revealed the insulin should be marked with a discard date when it was opened and thrown away on that date.

Observation in the house 2 medication room at 11:00 a.m. on 12/10/13 revealed revealed two NovoLog insulin FlexPens, and one Levemir FlexPen opened and stored in the refrigerator.

Interview on 12/10/13 at 11:00 a.m. with licensed nursing staff HH reported all three insulin pens were open and used for residents.

Observation on 12/10/13 at 11:18 a.m. in the house 1 medication room revealed a Humalog insulin KwikPen and a Levemir insulin FlexPen in the refrigerator open and in use for residents.

Interview on 12/10/13 at 11:18 a.m. with licensed nursing staff NN confirmed the refrigerated insulin pens were in use for the residents.

Observation on 12/10/13 at 11:18 a.m. in the house 1 medication room refrigerator revealed an opened multi-dose vial of Flulaval influenza vaccine. The vial was dated as opened on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 431	Continued From page 103	F 431		

11/11/13.

Interview with licensed nursing staff NN on 12/10/13 at 11:18 a.m. revealed Flulaval vaccine remained good until the manufacturer's expiration date and confirmed staff opened the bottle on 11/11/13.

Review of the package insert for NovoLog FlexPens revealed in use pens required storage at room temperature.

Review of the package insert for Levemir FlexPens revealed in use pens required storage at room temperature.

Review of the package insert for Humalog KwikPens revealed in use pens required storage at room temperature.

Review of the package insert for Flulaval influenza vaccine revealed, "Once entered, a multi-dose vial should be discarded after 28 days."

Interview with administrative nursing staff A on 12/17/13 at 5:31 p.m. revealed the pharmacist checked for expired medications and he/she also did. Staff reported the pharmacist had checked twice and he/she had checked three times in the past 6 weeks.

Interview with consultant staff QQ on 12/18/13 at 2:40 p.m. revealed it was his/her understanding that checking for expired medications was a nursing function as part of the facility's quality assurance program. Staff QQ reported insulin pens should be stored unrefrigerated. Staff QQ reported according to the package insert, he/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 431	Continued From page 104	F 431		

thought even after a vial of Flulaval was opened, it was good until the manufacturer's expiration date.

Review of the facility policy for Storage of Medications, revised 11/11, revealed, "Outdated... medications... are immediately removed from inventory, disposed of according to procedures for medication disposal, ... and reordered from the pharmacy... Medication storage conditions are monitored on a [monthly] basis by [the consultant pharmacist or pharmacy designee] and corrective action taken if problems are identified... Certain medications... such as ... multiple dose injectible vials... once opened, require an expiration date shorter than the manufacturer's date to insure medication purity and potency... When the... vial is initially brokent, the container or vial will be dated. 1) The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration... The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating."

Review of the facility's undated policy for Administration of Insulin Injections revealed, "Vials/Cartridges of insulin that are in use may be stored at room temperature for a period of 4 weeks. However after this time if any insulin is left it should be discarded."

The facility failed have a system to ensure staff labeled medications and ensure expired medications were discarded as planned and failed to store insulin pens per the manufacturer's recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 441 F 441 SS=F	Continued From page 105 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 441	Continued From page 106	F 441		

This REQUIREMENT is not met as evidenced by:
The facility census totaled 72 residents. Based on observation, interview, and record review, the facility failed to have an infection control program that prevented staff from potentially spreading infections through the failure to change gloves and wash hands between touching potentially contaminated items and clean items during peri-care and when changing wound dressings. (#39 and 189) It also failed to develop a standard of following the manufacturer's recommendations related to the use of a disinfectant for cleaning resident rooms. This failure had the potential to affect all 72 residents.

Findings included:

- Review of the manufacturer's directions for the use of dispatch (a disinfectant cleaner) on the spray bottle instructed: in order to kill C-diff (clostridium difficile) spores (a contagious bacteria characterized by foul smelling frequent bowel movements) spray area and let set for 5 minutes, wipe with rag or paper towel and allow to air dry.

On 12-17-13 at 7:10 a.m. housekeeping staff CC stated the facility had residents with C-diff and planned to clean those rooms today. He/she stated the staff used the dispatch disinfectant cleaner on the mattress when someone was discharged from the room. Staff CC also stated they sprayed the sinks, toilet tank, seat and outside of the bowl and then wipe it off with a rag. He/she stated the housekeepers got a census every morning and residents who had C-diff were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 441	Continued From page 107	F 441		

marked so staff knew to use the dispatch product. Staff CC also stated the disinfectant cleaner, dispatch and 20 neutral (another type of disinfectant cleaner) did not have a " wet time " (a specific time the surface needed to remain wet to be effective).

Observation on 12-17- 13 at 8:07 a.m. housekeeping staff CC gathered items needed to clean an isolation room. He/she had a spray bottle of dispatch and sprayed the vanity around the sink and then immediately wiped it with a dry rag without allowing the product to remain on the surface as the manufacturer directed. Staff CC sprayed the toilet tank, outside of the bowl, and the toilet seat with 20 neutral disinfectant spray and then wiped it with the personal hygiene wipes. Staff CC continued to clean the rest of the bathroom and bedroom area and did not use the dispatch cleaner on any other high risk areas in the resident's room. After staff CC finished cleaning the room, he/she looked at the label on the dispatch spray bottle and stated it instructed to spray and let set for 5 minutes and then wipe with a rag. Stated he/she had not seen that before.

On 12-17-13 at 12:42 p.m. housekeeping staff AA stated the dispatch had a wet time of 5 minutes.

Review of the undated clostridium difficile (C-diff) policy revealed guidelines for providing care for persons with C-diff included: disinfection of items with fecal soiling (such as bed pans, commode chair, bed rails, etc.) and disinfecting of shared items which could be fecally contaminated between resident usage.

The facility failed to follow the manufactures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 441	Continued From page 108	F 441		

recommendations for use of disinfectants to ensure infections did not spread throughout the facility which had the potential to affect all residents in the facility.

- On 12/16/13 at 7:13 a.m., observation revealed Licensed nurse Y prepared to change the wound dressings on resident #189 as the resident laid in bed. Direct care staff B assisted nurse Y by assisting the resident to lie on his/her right side in bed. Nurse Y washed his/her hands, then applied clean gloves. The nurse then removed the soiled dressings, one on the resident's hip, the other on the buttock. The nurse then used a syringe full of saline and wet a number of 2 x 2 gauze pads. The nurse took 1/2 of the wet gauze pads and cleaned the hip wound, then used the remaining gauze pads to cleanse the wound on the buttock. The nurse then placed clean dressings on both wounds. The nurse then collected his/her trash, off the bed, threw the trash away, and then removed the one set of gloves used for the treatment of both wounds, washed his/her hands, and left the room.

On 12/17/13 at 2:20 p.m., Administrative nurse A, when told of the concern with not changing gloves between handling dirty and clean dressings, as well as between two wounds, nurse A sighed and shook his/her head.

Review of the facility's undated Pressure Ulcer policy provided the following guidance to staff:
"Put on gloves and remove the soiled dressing.
Remove gloves and discard soiled dressing and gloves in the appropriate receptacle.
Wash and dry your hands thoroughly and put on gloves.
Cleanse the ulcer with gauze soaked in normal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 441	Continued From page 109	F 441		

saline, unless the physician has ordered another cleansing solution. Use gentle force to remove dead tissue and old drainage, but do not damage new tissue.
Dry the skin surrounding the pressure by patting with a clean gauze.
Remove your gloves and discard your gloves and the soiled gauze into the appropriate receptacle.
Wash and dry your hands and put on clean gloves."

The facility failed to follow their policy on glove change usage during dressing changes to prevent infections in wounds.

- Observation on 12/16/13 at 7:26 a.m. revealed direct care staff B and direct care staff I changed the incontinent brief of resident #189, who had experienced urinary incontinence. Staff B provided perineal care to the resident, and without changing the soiled gloves, reached over to the bedside dresser drawer, opened it, and removed a small cup that held a white cream. Staff B closed the drawer and then spread the white cream on the perineal area of the resident. Once done, staff B and I then applied a clean brief, then staff B removed the soiled gloves.

On 12/17/13 at 1:30 p.m., Licensed nurse W stated that staff are not to touch items in the resident's room with the same gloves after they have provided perineal care. The staff are to change their gloves first, and this includes tubes of moisture barrier, the side rails, the mechanical lifts, and even packages of wipes.

Review of the facility's undated policy on Using Gloves revealed it failed to provide guidance to staff on when to remove soiled gloves in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 441	Continued From page 110	F 441		

resident's rooms.

The facility failed to have an infection control program that directed staff to remove soiled gloves prior to touching other surfaces in resident rooms to prevent cross-contamination.

- On 12/16/13 at 7:22 a.m., observation revealed direct care staff B and direct care staff I changed the wet incontinent brief of resident #39. Staff B used pre-moistened wipes to provide perineal care to the resident. Staff I turned from the bed toward the resident's bedside dresser to obtain some moisture barrier, and staff B stood up and took a step backward. As staff B did this, he/she bumped into the mechanical lift that was in the room. Staff B moved the lift farther away so not to bump into it again, but did so with the same gloves that he/she had used to provide perineal care to the resident. Staff I found the moisture barrier, squeezed a moderate amount onto the gloves of staff B, who then put the moisture barrier on the resident's buttocks. The staff applied a clean brief, then used removed their gloves and washed their hands before assisting the resident from the bed into the wheelchair with the use of the mechanical lift.

On 12/17/13 at 1:30 p.m., Licensed nurse W stated that staff are not to touch items in the resident's room with the same gloves after they have provided perineal care. The staff are to change their gloves first, and this includes tubes of moisture barrier, the side rails, the mechanical lifts, and even packages of wipes.

Review of the facility's undated policy on Using Gloves revealed it failed to provide guidance to staff on when to remove soiled gloves in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 441	Continued From page 111 resident's rooms. The facility failed to have an infection control program that directed staff to remove soiled gloves prior to touching other surfaces in resident rooms to prevent cross-contamination.	F 441		
F 520 SS=F	- 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

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F 520	Continued From page 112	F 520		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 72 residents. Based on interviews and deficiencies cited under the quality of care and quality of life, the facility failed to maintain a quality assessment and assurance (QA&A) committee that identified quality of life and quality of care problems, and developed, implemented and reviewed appropriate plans of action to correct the quality deficiencies. This failure had the potential to affect all 72 residents in the facility.

Findings included:

- Interview with Administrative Staff A on 12-17-13 at 3:45 PM revealed the facility had had alot of different leadership personel and had gone through a lot of changes, however, the QA committee had been investigating and reviewing a multitude of different care areas as well as all the departments and were actively reviewing the policies to make sure the staff are delivering quality care for the residents.

The following quality deficiencies were identified during the survey process:

* The facility census totaled 72 residents with 23 included in the sample. Based on observation and interview, the facility failed to provide dignified care for 4 residents by the failure of staff to knock and receive permission to enter resident rooms, request permission to provide a treatment, and refrain from using a cell phone while feeding a resident Please see F 241 for additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 520	Continued From page 113	F 520		

* The facility census included 72 residents with 23 in the sample. Based on observation, interview, and record review the facility failed to provide medically-related social services for 1 of 3 residents reviewed for dental services. Please see F250 for additional information.

* The facility census totaled 72 residents. Based on observation and interview the facility failed to provide housekeeping and maintenance services to distinguish personal toiletries, including tooth brushes, and washcloths for residents in semi-private rooms to ensure each resident had sanitary, orderly conditions. This had the potential to affect 20 residents. Please see F253 for additional information.

* The facility census totaled 72 residents that lived in 4 houses. Based on observation and interview the facility failed to ensure sound levels did not interfere with resident's ability to participate in social interaction for residents who ate breakfast in 3 of the 4 dining rooms. Please see F 258 for additional information.

* The facility census totaled 72 residents with 23 in the sample. The sample included the review of the comprehensive care plans for 22 residents. Based on observation, interview, and record review, the facility failed to develop specific, individualized care plans for 9 of 22 sampled residents involving dental hygiene, specific targeted behaviors, indwelling Foley catheters, choices regarding sleeping arrangements and monitoring of the shunt site for a dialysis patient. Please see F 279 for additional information.

* The facility had a census of 72 with 23 sampled residents. One of the 23 sampled residents was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 520	Continued From page 114	F 520		

reviewed for dialysis. Based on observation, record review, and interview the facility failed to provide the necessary daily monitoring and failed to communicate care with the outside dialysis facility in order to maintain the highest practicable standards of care for a resident who received dialysis services. Please see F 309 for additional information.

* The facility census totaled 72 residents with 23 included in the sample. Based on observation, interview, and record review, the facility failed to provide nail care and facial hair grooming for 1 of 3 residents reviewed for ADL (activities of daily living) assistance and to provide oral care for 1 of 3 reviewed for dental services. Please see F 312 for additional information.

* The facility had a census of 72 with 23 sampled residents. One of the 23 residents were reviewed for pressure ulcers. Based on observation, record review and interview the facility failed to ensure a resident with an on going history as well as current pressure ulcers received necessary treatment and services to promote healing, and prevent new sores from developing by failure to provide timely repositioning Please see F 314 for additional information.

* The facility had a census of 72 with 23 sampled residents. One of the 23 residents were reviewed for pressure ulcers. Based on observation, record review and interview the facility failed to ensure a resident with an on going history as well as current pressure ulcers received necessary treatment and services to promote healing, and prevent new sores from developing by failure to provide timely repositioning Please see F 315 for additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

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F 520	Continued From page 115	F 520		

* The facility census totaled 72 residents with 23 included i nthe sample. The sample included the review of 4 resident with accidents. Based on observation, interview and record review, the facility failed to determine the root cause of falls in order to develop effective interventions that included suffiecient supervision and assistive devices to prevent additional falls for 2 of 4 sampled residents. Please see F 323 for additional information.

* The facility census totaled 72 residents with 23 included in the sample. Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for nutrition received with a planned nutritional supplement. Please see F 325 for additional information.

* The facility census totaled 72 residents with 23 residents sampled. Of those, 5 residents were reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to identify and monitor specific behaviors related to medications for 3 of 5 residents. Please see F 329 for additional information.

* The facility census totaled 72 residents. Based on observation and interview the facility failed to have sufficient staff to provide necessary care and services, including supervision, to ensure resident needs as care planned were met. This had the potential to affect all residents in the facility. Please see F 353 for additional information.

* The facility had a census of 72 residents with 18 resident residing in Angela Joseph hall. Based on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 520	Continued From page 116	F 520		

observation, recored review and interview the facility failed to maintain the proper holding food temperatures for food available to be served to the residents Please see F 364 for additional information.

* The facility census included 72 residents. Based on observation and interview, the facility failed to ensure dietary staff effectively used hair restraints in 3 of 4 kitchens and to ensure the resident's were not served contaminated food. Please see F 371 for additional information.

* The facility census totaled 72 residents. The sample included the review of the medication regimen of 5 residents. Based on observation, interview and record review, the pharmacist failed to identify the facility's lack of a program that ensured staff identified targeted behaviors for each psychoactive medication and monitored the effectiveness to ensure the continued necessity of each psychoactive medication for 3 of 5 sampled residents. Please see F 428 for additional information.

* The facility census included 72 residents. Based on observation, record review, and interview, the facility failed to have a pharmaceutical system for labeling medications and discarding expired medications. This failure had the potential to affect all residents residing in the facility.
Please see F 431 for additional information.

* The facility census totaled 72 residents. Based on observation, interview, and record review, the facility failed to have an infection control program that prevented staff from potentially spreading infections through the failure to change gloves and wash hands between touching potentially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175514	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERBY HEALTH & REHABILITATION LLC	731 KLEIN CIRCLE DERBY, KS 67037

(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 520	Continued From page 117 contaminated items and clean items during peri-care and when changing wound dressings. (#39 and 189) It also failed to develop a standard of following the manufacturer's recommendations related to the use of a disinfectant for cleaning resident rooms. This failure had the potential to affect all 72 residents. Please see F 441 for additional information. The facility failed to develop and implement and effective system to ensure that action plans were developed through the QAA program to address concerns related to resident care.	F 520		