STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREELEY COUNTY HOSPITAL LTCU	**506 3RD STREET PO BOX 338 TRIBUNE, KS 67879**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included three resident reviewed for behaviors. Based on observation, record review and interview, the facility failed to revise the care plan for Resident (R) 1 who made frequent statements of wanting to die and history of self-harm. Findings included: - R1's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired decision making skills, disorganized thinking, physical behaviors directed toward others, and felt he was a failure two to six days during the look back period. The MDS documented the resident required extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. The Behavior Care Area Assessment (CAA), dated 04/14/20, documented the resident had physical and verbal behaviors and rejected care. The Behavior Care Plan, dated 04/16/20, documented the resident had behaviors related to dementia without behavioral disturbance (a condition where the person loses the ability to think, remember, learn, make decisions, and solve problems). The care plan directed staff to monitor the resident's aggressive behaviors, if the resident displayed aggressive behaviors, interventions would be implemented, and care plan updated. The care plan failed to document the resident made statements of wanting to die and of self harm and lacked direction for these behaviors. The Psychiatric Physician Encounter Document, dated 04/14/20, documented staff stated the resident often made comments to staff to take a hammer and bop him over the head, and he could just fall down and hit his head. The document stated the resident denied having any suicidal or homicidal ideation's of intent or plan to harm himself. The Nurse's Note, dated 07/03/20 at 08:00 PM, documented on 06/27/20, staff found the resident, in his room, with the call light cord wrapped around himself and the wheelchair. The note further documented the resident frequently made remarks referring to self-harm, such as I'm going to fall and break my neck, I'll run out in front of a truck, or hit me in the head with a hammer. On 08/11/20 at 03:00 PM, observation revealed the resident said hello and staff took the resident to the dining room for an activity. Further observation revealed the resident played bingo and talked with the activity staff. On 08/11/20 at 10:45 AM, Certified Nurse Aide (CNA) M stated the resident often made negative statements about death and asked staff to get a hammer and hit him in the head with it. CNA N further stated, staff spend time with the resident and take him to activities when he talked that way. On 08/11/20 at 02:15 PM, Administrative Nurse D verified the behavior care plan did not have specific interventions to assist staff when resident made remarks regarding death and suicidal behaviors. The facility's Care Plan policy, dated 11/ 29/19, documented the care plan was to provide proper care for residents and to ensure accurate documentation and information to the resident and their family or medical representative by using the results of the resident assessment to develop, review and revise the resident comprehensive care plan. The policy further documented corrections and changes would be made to the resident's care plan by editing it as needed between care plan meetings. The facility failed to revise R1's care plan with interventions for staff when the resident made remarks of death and self-harm, placing the resident at risk for harm.

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

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