

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/02/2015
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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208
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S 000	<p>INITIAL COMMENTS</p> <p>The following citations represent the findings of complaint investigation #83219.</p> <p>A revision letter was sent to the facility on 2/18/15.</p>	S 000		
S3261 SS=D	<p>26-41-105 (f) (11) Resident Record Documentation of Incidents</p> <p>(f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action</p> <p>This REQUIREMENT is not met as evidenced by: The facility memory care unit census totaled 22 residents with 3 residents sampled. Based on observation, record review, and interviews, the facility failed maintain complete medical records for 3 of 3 residents (#1, #2, and #3).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident # 1's history and physical dated 5/26/14 included the diagnosis of Alzheimer's disease - a progressive mental deterioration characterized by confusion and memory failure. <p>The 1/8/15 updated service and health update documented the resident required the assistance of 1 staff person with mobility, transferring, grooming, dressing, and dining, and 2 staff person assistance to the bathroom. The resident refused care, need redirection/assurance, repetitive behaviors, combative or aggressive,</p>	S3261		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3261	<p>Continued From page 1</p> <p>and impaired safety awareness and/or decision making ability. The resident had behaviors of yelling out and cursing.</p> <p>The 9/8/14 revised negotiated service agreement documented the resident had memory loss related to dementia - a progressive mental disorder characterized by failing memory and confusion, with interventions to ask 'yes/no' questions in order to help determine the resident's needs; cue, reorient and supervise or assist as needed; engage the resident in life skills based on their interests and abilities of choosing their clothing options, making the bed, folding clothes and linens, and reading; keep the resident's routine consistent by providing a designated care manager in order to ensure their sense of security, routine, predictability, success, and minimize their uncertainty or confusion; and present the resident with just one thought, idea, question or request at a time.</p> <p>Added on 1/2/15 the resident has a skin tear of the right wrist related to fragile skin which measured 6.8 centimeters (cm) by 0.8 cm. The interventions included to encourage good nutrition and hydration in order to promote healthier skin and weekly treatment documentation to include measurements for each area of skin breakdown with width, length, depth, type of tissue, drainage, and any other notable changes or observations. The nurse should report any improvements and/or declines to the physician.</p> <p>The nurses' notes documented the following:</p> <p>On 10/16/2014 at 7:26 A.M. a care manager observed the resident's family member slap the resident on the arm on 10/15/14.</p>	S3261		

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S3261	<p>Continued From page 2</p> <p>On 10/16/14 at 7:33 A.M. staff found a bruise and skin tear on the resident's right arm.</p> <p>On 10/16/14 at 8:32 A.M. staff noted the resident and family member walking to the dining room and noted the resident's right arm purple in color and not swollen. The purple area measured 12 cm from the elbow to the wrist and approximately 5 cm across. The resident expressed "ouch" when staff touched the right arm.</p> <p>On 10/16/14 at 10:30 A.M. staff notified the family member of the bruise and the investigation related to the bruise.</p> <p>On 10/17/14 at 5:21 P.M. the physician assessed the right arm and the skin tear that measured 1 by 1 cm that was scabbed over, no active bleeding, no redness, and no signs or symptoms of infection. The resident denied pain.</p> <p>The medical record lacked further documentation related to this skin tear and the bruise.</p> <p>On 1/2/2015 at 2:52 P.M. two staff members attempted to transfer the resident from the wheelchair to the toilet with resident using the grab bar. The resident rubbed his/her right wrist against the wall and a skin tear which measured 6.6 cm by 0.8 cm was created.</p> <p>On 1/3/2015 at 4:57 P.M. the resident was in a wheelchair, guarded his/her right wrist, and screamed when the skin tear was touched. The area was cleaned and 8 steri strips (strips used to hold skin together) applied to the skin tear, then covered dressing.</p> <p>On 1/6/2015 12:50 P.M. staff noted the resident's right wrist, hand, and forearm red, swollen and</p>	S3261		

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S3261	<p>Continued From page 3</p> <p>warmth to touch.</p> <p>The medical record lacked further documentation related to skin tear and skin condition.</p> <p>On 1/13/2015 12:48 P.M. staff observed the resident with a 4 minute episode of a type of trembling which then suddenly stopped. The resident felt warm to touch and had a temperature of 100.5 degrees Fahrenheit. The resident was sent to the hospital at 2:18 P.M.</p> <p>On 1/29/15 at 1:30 P.M. interview with direct care staff Q stated she/he saw the family member hit the resident on the right arm on 10/15/14.</p> <p>On 1/29/15 at 3:00 P.M. direct care staff P stated he/she transferred the resident onto the toilet by using the grab bar. The resident's hand got caught in the grab bar and the resident received a skin tear.</p> <p>On 1/29/15 at 11:35 A.M. administrative nursing staff B acknowledged the clinical record lacked follow up documentation related to incident with family and the bruising/skin tears.</p> <p>On 1/29/15 at 12:43 P.M. administrative staff A stated he/she does not document in the resident's medical record and all the information related to the incident where family was observed hitting the resident was sent to the corporate office and he/she did not have access to the information.</p> <p>The 1/17/12 revised facility policy "Progress Notes- Automated Care System" instructed designated individuals (executive director, assisted living coordinator, health coordinator, reminiscence coordinator, and wellness nurse) would record all observations, conversations, and</p>	S3261		

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S3261	<p>Continued From page 4</p> <p>changes in condition regarding a resident in the automated care system. The progress notes would be maintained in the resident's electronic file. The executive director (administrator) would document conversations held with family/responsible party. This may include monthly contact with families/responsible party. The relevant information included, but not limited to special concerns. When documenting the notes should be complete and thorough.</p> <p>The facility failed to maintain a complete and accurate medical record for this dependent resident related to incident with family member and follow up skin conditions.</p> <p>- Resident #2's service plan dated 8/1/14 documented the diagnosis of dementia - a progressive mental disorder characterized by failing memory and confusion.</p> <p>The service and health plan updated on 1/16/15 documented the resident required the physical assistance of 1 staff member with all activities of daily living, needed redirection, had impaired safety awareness and impaired decision making. The resident with no health related concerns.</p> <p>The 1/16/15 care plan documented the resident required end of live care with the interventions to adjust personal care needs according to the resident's changing abilities, encourage participation to the extent the resident wishes to or is able to be involved, collaborate with other team members to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, encourage independence, and provide assistance to resident with daily care tasks as needed, per resident preference, and allow for</p>	S3261		

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S3261	<p>Continued From page 5</p> <p>frequent rest periods between tasks per resident preference or condition.</p> <p>The clinical record documentation on 1/16/2015 at 9:15 A.M. documented the staff noted the resident with combativeness this morning, unable to comprehend statements made by the staff, refused assistance to get dressed, and did not want to come down to eat breakfast.</p> <p>On 1/24/2015 at 8:38 A.M. the staff documented the resident up in the wheelchair this morning. Staff noted that resident had more labored breathing yesterday; today it is less noticeable and the resident was unable to answer if in pain.</p> <p>On 1/24/2015 at 6:18 P.M. staff left a message for outside services to call the resident's family about therapy order.</p> <p>No further documentation was written by the facility.</p> <p>A telephone order was written on 1/26/14 to release the resident's body to the mortuary.</p> <p>On 1/29/15 at 12:10 P.M. administrative staff B stated the resident expired on 1/26/15 at 1:13 A.M. and acknowledge the clinical record lacked documentation related to an outside service and the resident's family at the resident's bedside the evening before his/her death. The clinical record lacked documentation to decline in the resident's condition.</p> <p>The 1/17/12 revised facility policy "Progress Notes- Automated Care System" instructed designated individuals (executive director, assisted living coordinator, health coordinator, reminiscence coordinator, and wellness nurse)</p>	S3261		

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S3261	<p>Continued From page 6</p> <p>would record all observations, conversations, and changes in condition regarding a resident in the automated care system. Progress notes would be maintained in the resident's electronic file.</p> <p>The facility failed to maintain complete medical records for this resident whose condition declined and he/she died at the facility.</p> <p>- Resident #3's service evaluation and health assessment dated 10/30/14 documented the resident required physical assistance with bathing, toileting, dressing, and walking. Resident able to recall recent events. The resident was able to demonstrate long term memory, did not have difficulty with memory/recall, and was able to make consistent, reasonable and organized decisions.</p> <p>The updated 10/28/14 service plan documented the resident was at risk for falls due to use of assistive device with interventions for the staff to become familiar with the resident's daily routine and attempt to anticipate and meet the resident's needs daily.</p> <p>The clinical record documented on 10/28/2014 at 2:15 P.M. a recommendation with a dedicated a 3 view elbow radiographs - a photograph by the action of certain rays on a specific surface. The clinical record lacked any documentation related to the facility's follow up concerning the recommended tests.</p> <p>On 1/29/15 at 9:30 A.M. resident observed sitting in the waiting room with other residents for morning medications. The resident did not recall living on another unit before moving here.</p> <p>On 1/29/15 at 4:00 P.M. administrative staff A</p>	S3261		

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S3261	<p>Continued From page 7</p> <p>stated he/she was unaware of recommendations regarding follow up concerning the elbow x-rays.</p> <p>The 1/17/12 revised facility policy "Progress Notes - Automated Care System" instructed coordinator to transfer relevant information from the daily log to the progress notes on a daily basis. When documenting late entries or reported incidence the nurse instructed to begin the documentation with either late entry for (date) and begin the note, or reported on (date, time or shift) by (staff) and begin the note.</p> <p>The facility failed to follow up on recommendation related to an x-ray for this resident's right elbow in October 2014.</p>	S3261		