

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B087153	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2016
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NAME OF PROVIDER OR SUPPLIER ACCORD SENIOR CARE INC - ROCKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 6807 E ROCKWOOD ROAD WICHITA, KS 67206
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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint #103943 at the above named facility on 8-22-16, 8-23-16, 8-24-16, 8-29-16, and 8-30-16.	S 000		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S5028		

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

TITLE

(X6) DATE

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S5028	<p>Continued From page 1</p> <p>KAR 26-42-105(f)(3)(A)(B)(C)(E)(F)</p> <p>The facility identified a census of 8 residents. The sample included 3 residents and 1 focus review. Based on 3 (#100, #200, #300) of 3 residents sample and 1 (#400) of 1 focus review, the operator failed to report each allegation of abuse, neglect, to the department within 24 hours, conduct an investigation, implement immediate measures to prevent further potential abuse or neglect, thoroughly investigate, complete the department's complaint investigation report and submit to the department within five working days of report and a written record shall be maintained of each investigation of reported abuse or neglect.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for resident #100 revealed admit date of 5-19-16 with diagnoses atrial fibrillation, rheumatoid arthritis, venous insufficiency, legally blind, anxiety, difficulty walking, and edema. <p>The annual Functional Capacity Screen (FCS) dated 5-19-15 and the significant change FCS dated 4-19-16 recorded resident independent with cognition, communication, required supervision with eating, physical assistance with bathing, dressing, toileting, transfer, walking/mobility, unable to assist with management of medications/treatments, experienced impaired vision due to being legally blind, and falls/unsteadiness.</p> <p>The NSA/HCS dated 4-19-16 recorded physical assistance with shower, dressing, grooming, transfer, ambulation, uses bedside commode, facility staff to administer and manage medications and treatments.</p>	S5028		

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S5028	<p>Continued From page 2</p> <p>The progress notes recorded the following:</p> <p>10-9-15 (no time), resident requested family member to take resident to an emergency room because of hip pain and generalized fatigue. Operator notified for recommendation and was informed resident had been admitted to hospital with diagnosis hematoma of hip and possible anemia.</p> <p>Record lacked documentation or investigation to rule out abuse or neglect and was not reported to the department within 24 hours.</p> <p>3-9-16 (no time), bruise noted on left arm 20 Centimeters (CM) by 14 CM. Resident on coumadin therapy. Resident had a doctor appointment on 3-10-16 at 2:30 p.m.</p> <p>The record lacked documentation or investigation to rule out abuse or neglect and was not reported to the department within 24 hours.</p> <p>4-12-16 (no time) resident had gone to emergency room by family member on 4-4-16 and had partial hip surgery on 4-5-16. Resident transferred from hospital on 4-8-16 to rehabilitation facility.</p> <p>The record lacked documentation or investigation to rule out abuse or neglect and was not reported to the department within 24 hours.</p> <p>The progress notes lacked documentation of an injury where resident fell on walker causing a chest contusion. The faxed medical care provider orders dated 8-2-16 recorded, "breast contusion from fall". The emergency room visit from hospital dated 7-20-16 recorded resident</p>	S5028		

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S5028	<p>Continued From page 3</p> <p>had a chest contusion.</p> <p>The record lacked documentation or investigation to rule out abuse or neglect and was not reported to the department within 24 hours.</p> <p>Interview on 8-23-16 at 10:45 a.m. with licensed nurse B stated, "Documented large bruise on left arm and did not recall how he/she became aware of the bruise. I did not document complaint of hip pain nor when resident complained of pain in left arm. Licensed nurse B also stated and confirmed the record lacked documentation when resident fell onto walker and had dark bruising under chin and across chest. Resident was diagnosed with a contusion on chest after went to the emergency room."</p> <p>- Record review for resident #200 revealed an admit date of 3-11-14 with diagnoses of dementia with behaviors and hypothyroidism.</p> <p>The annual FCS dated 11-18-15 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, communication, unable to assist with management of medications/treatments, bladder incontinence, experienced short term memory loss, memory recall, long term memory loss, decision making, impaired decision making, and fall/unsteadiness. Resident does not speak English.</p> <p>The annual NSA/HCS dated 11-18-15 recorded resident #200 required total assistance for eating/feeding pureed diet, one person physical assistance with bathing, dressing, grooming,</p>	S5028		

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S5028	<p>Continued From page 4</p> <p>transfers, ambulation short distance, use wheel chair for long distance, physical assistance with toileting, repositioning, body alarm when in bed, facility staff to administer medications/treatments as ordered by medical care provider.</p> <p>The progress notes recorded:</p> <p>8-17-16 (no time) Resident had sustained an injury to right index finger during the night of 8-15-16 at 1:30 a.m. Informed the medical care provider, family came and took resident to immediate medical care. Resident had multiple steri-strips applied and wrapped hand with ace wrap.</p> <p>The record lacked documentation or investigation to rule out abuse or neglect and was not reported to the department within 24 hours.</p> <p>8-22-16 medical care provider orders to consult home health to provide wound care, cleanse finger/wound with betadine, pat dry with gauze, cover with xeraform dressing and gauze, kerlix or wrap with ace wrap three times a week.</p> <p>8-22-16 at 1:25 p.m. observed licensed nurse B remove dressing from right hand index finger. Observed one and one half inch tear on finger from base of finger to knuckle. Several steri-strips in place. The tear on right index finger red around site. Finger splint replace and wrapped with ace wrap. Sock applied over right had to keep resident from pulling at dressing.</p> <p>- Record review for resident #300 revealed an admit date of 6-7-14 with diagnoses of dementia with behaviors, hypertension, dyskinesia,</p>	S5028		

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S5028	<p>Continued From page 5</p> <p>hypothyroidism, depression, and anxiety.</p> <p>The FCS dated 1-21-16 recorded resident unable to assist with bathing dressing, toileting, transfer, walking/mobility, eating, management of medications/treatments, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, and impaired decision making.</p> <p>The NSA/HCS dated 1-20-16 recorded resident total assist with feeding pureed diet, facility management of medication administration and treatments administer as ordered by medical care provider. Resident required physical assistance with bathing, dressing, grooming, transfers, non-ambulatory, toileting, and oral care. Hospice services as ordered.</p> <p>The progress notes recorded the following:</p> <p>1-19-16 (no time) new order from hospice for stage two wound to left buttock. Clean with wound cleanser, apply medi honey to wound bed, cover with opti foam and change every seven days.</p> <p>The record lacked documentation or investigation to rule out abuse or neglect and was not reported to the department within 24 hours.</p> <p>History and physical dated 2-29-16 recorded: Chief complaint: Pressure ulcer follow up. 1. Pressure ulcer restart antiseptic ointment to excoriated are four times a day and with every change of depends.</p> <p>Observation on 8-22-16 at 1:10 p.m. certified staff C transfer resident from wheel chair to toilet. Observed excoriated perineal area. Coccyx red</p>	S5028		

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S5028	<p>Continued From page 6</p> <p>and two centimeter open area noted top right inside buttock. Skin peeling around area. Incontinent care provided and caloseptine cream applied to area. Resident lacked heel protection to protect against pressure ulcers as ordered on 12-28-15.</p> <p>Review of the Medication Administration Record (MAR) lacked documentation for treatment of open wound on right buttock.</p> <p>The record lacked documentation or investigation to rule out abuse or neglect and was not reported to the department within 24 hours.</p> <p>Interview on 8-24-16 at 10:50 a.m. with licensed nurse B stated and confirmed the record lacked documentation of treatment to open wound on buttock.</p> <p>- Record review for resident #400 revealed an admit date of 2-11-13 with diagnoses of osteopenia, osteoporosis, metastatic bone disease, rheumatoid arthritis, and Alzheimer ' s disease.</p> <p>The FCS dated 6-7-15 recorded resident unable to assist with bathing dressing, toileting, transfer, required physical assist with walking/mobility and eating, unable to manage medications/treatments, experienced short-term memory loss, memory recall, long-term memory loss, decision making, impaired decision making and socially inappropriate disruptive behaviors.</p> <p>The NSA/HCS dated 5-21-15 recorded resident is total assist with eating, pureed diet, staff to manage medications/treatments as ordered, resident yells out loudly for no apparent reason, physical assist with bathing dressing, grooming</p>	S5028		

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S5028	<p>Continued From page 7</p> <p>transfer, toileting and is non ambulatory.</p> <p>The record documented on 5-5-26 hospice staff reported to certified staff after giving bath that resident's foot was red and appeared swollen. Licensed nurse B notified hospice on call nurse who came to the facility. Medical care provider and family notified by phone. Resident not able to flex foot, does not flinch or cry out when foot is being touched. The medical care provider ordered an x-ray and the report identified a fracture of the distal right tibia.</p> <p>The department was not notified within 24 hours of incident.</p> <p>Interview on 8-23-16 with operator stated and confirmed he/she did not complete the department's investigation report within 5 working days.</p> <p>For residents #100, #200, #300, and #400, the operator failed to report each allegation of abuse, neglect, to the department within 24 hours, conduct an investigation, implement immediate measures to prevent further potential abuse or neglect, thoroughly investigate, complete the department's complaint investigation report and submit to the department within five working days of report and a written record shall be maintained of each investigation of reported abuse or neglect.</p>	S5028		
S5161 SS=E	<p>26-42-204 (d) Health Care Services</p> <p>(d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed</p>	S5161		

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S5161	<p>Continued From page 8</p> <p>nurse responsible for the implementation and supervision of the plan.</p> <p>This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d)</p> <p>The facility identified a census of 8 residents. The sample included 3 residents and 1 focus review. Based on 3 (#100, #200, #300) of 3 residents sampled, the operator failed to ensure the Negotiated Service Agreement (NSA) contained a description of Health Care Services (HCS) to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for resident #100 revealed admit date of 5-19-16 with diagnoses atrial fibrillation, rheumatoid arthritis, venous insufficiency, legally blind, anxiety, difficulty walking, and edema. <p>The annual Functional Capacity Screen (FCS) dated 5-19-15 and the significant change FCS dated 4-19-16 recorded resident independent with cognition, communication, required supervision with eating, physical assistance with bathing, dressing, toileting, transfer, walking/mobility, unable to assist with management of medications/treatments, experienced impaired vision due to being legally blind, and falls/unsteadiness.</p> <p>The NSA/HCS dated 4-19-16 recorded physical assistance with shower, dressing, grooming, transfer, ambulation, uses bedside commode, facility staff to administer and manage</p>	S5161		

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S5161	<p>Continued From page 9</p> <p>medications and treatments.</p> <p>The progress notes recorded the following:</p> <p>10-9-15 (no time), resident requested family member to take resident to an emergency room because of hip pain and generalized fatigue. Operator notified for recommendation and was informed resident had been admitted to hospital with diagnosis hematoma of hip and possible anemia.</p> <p>10-12-15 (no time), was notified at 10:30 resident to be discharged from hospital and order for physical therapy and occupational therapy. Activities of ambulation with assistance only and advance as tolerated. To hold coumadin (blood thinner) until 10-19-15 due to abnormal labs.</p> <p>The NSA/HCS lacked interventions for falls/unsteadiness and how to progress with ambulation as tolerated and increased risk for bleeding due to coumadin therapy (blood thinner).</p> <p>3-9-16 (no time), bruise noted on left arm 20 Centimeters (CM) by 14 CM. Resident on coumadin therapy. Resident had a doctor appointment on 3-10-16 at 2:30 p.m.</p> <p>Emergency room visit from hospital dated 7-20-16 recorded resident had a chest contusion. A faxed medical care provider orders dated 8-2-16 recorded, "breast contusion from fall". The progress notes lacked documentation of an injury where resident fell on walker causing a chest contusion.</p> <p>The NSA/HCS lacked interventions for falls/unsteadiness, blindness, and resident at high risk for bleeding due to coumadin therapy (for</p>	S5161		

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S5161	<p>Continued From page 10</p> <p>thinning blood).</p> <p>Interview on 8-23-16 at 1:20 p.m. with resident #100 stated, "He/She had a large bruise on left arm and thought it was from a family member assisting him/her into a car. I had pain in my right hip for a while and decided he/she should go to the emergency room. At the emergency room found out he/she had a broken hip and had a partial hip repair. I then went from hospital to a rehabilitation facility then back home to this facility. I did fall on my walker hit my chin and chest on my walker. I do not recall the date but had dark bruising from neck and across chest from what a family member told me.</p> <p>Interview on 8-24-16 at 10:05 with licensed nurse B confirmed falls/unsteadiness interventions not in the NSA/HCS.</p> <p>- Record review for resident #200 revealed an admit date of 3-11-14 with diagnoses of dementia with behaviors and hypothyroidism.</p> <p>The annual FCS dated 11-18-15 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, communication, unable to assist with management of medications/treatments, bladder incontinence, experienced short term memory loss, memory recall, long term memory loss, decision making, impaired decision making, and fall/unsteadiness. Resident does not speak English.</p> <p>The annual NSA/HCS dated 11-18-15 recorded resident #200 required total assistance for eating/feeding pureed diet, one person physical</p>	S5161		

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S5161	<p>Continued From page 11</p> <p>assistance with bathing, dressing, grooming, transfers, ambulation short distance, use wheel chair for long distance, physical assistance with toileting, repositioning, body alarm when in bed, facility staff to administer medications/treatments as ordered by medical care provider.</p> <p>The progress notes recorded:</p> <p>8-17-16 (no time) Resident had sustained an injury to right index finger during the night of 8-15-16 at 1:30 a.m. Informed the medical care provider, family came and took resident to immediate medical care. Resident had multiple steri-strips applied and wrapped hand with ace wrap.</p> <p>8-19-16 faxed medical care provider orders recorded: to cleanse wound of right index finger with aseptic technique daily, apply 2 x 2 bandage and roll gauze daily, assess and maintain steri-strips on the wound, notify on call nurse of changes observed to the wound.</p> <p>8-22-16 medical care provider orders to consult home health to provide wound care, cleanse finger/wound with betadine, pat dry with gauze, cover with xeraform dressing and gauze, kerlix or wrap with ace wrap three times a week.</p> <p>8-22-16 at 1:25 p.m. observed licensed nurse A remove dressing from right hand index finger. Observed one and one half inch tear on finger from base of finger to knuckle. Several steri-strips in place. The tear on right index finger red around site. Finger splint replace and wrapped with ace wrap. Sock applied over right had to keep resident from pulling at dressing.</p> <p>On 8-22-16 at 12:58 p.m., observed certified staff</p>	S5161		

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S5161	<p>Continued From page 12</p> <p>D transfer resident from recliner to wheel chair, wheeled to restroom and transferred from wheel chair to toilet. Incontinent care provided and transferred in wheel chair to living room and transferred back to a recliner. During transportation observed two side rails on bed and no bed alarm. Certified staff D stated they do not use a body alarm anymore and side rails to be up when in bed.</p> <p>Interview on 8-24-16 at 10:25 p.m. with licensed nurse B stated and confirmed dressing change to right index finger not documented, body alarm was discontinued on 6-20-16, side rails up when resident in bed for repositioning, confirmed resident was cognitively impaired and did not speak English. Licensed nurse B also stated and confirmed the NSA/HCS lacked interventions for falls/unsteadiness, reason for side rails use on cognitive impaired resident, communication due to resident unable to speak English and interventions for wound care to right index finger.</p> <p>The NSA/HCS lacked the signature of the licensed nurse responsible for implementation and supervision of the HCS provided.</p> <p>- Record review for resident #300 revealed an admit date of 6-7-14 with diagnoses of dementia with behaviors, hypertension, dyskinesia, hypothyroidism, depression, and anxiety.</p> <p>The FCS dated 1-21-16 recorded resident unable to assist with bathing dressing, toileting, transfer, walking/mobility, eating, management of medications/treatments, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, and impaired decision making.</p>	S5161		

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S5161	<p>Continued From page 13</p> <p>The NSA/HCS dated 1-20-16 recorded resident total assist with feeding pureed diet, facility management of medication administration and treatments administer as ordered by medical care provider. Resident required physical assistance with bathing, dressing, grooming, transfers, non-ambulatory, toileting, and oral care. Hospice services as ordered.</p> <p>The progress notes recorded the following:</p> <p>1-19-16 (no time) new order from hospice for stage two wound to left buttock. Clean with wound cleanser, apply medi honey to wound bed, cover with opti foam and change every seven days.</p> <p>1-30-16 (no time) Resident seen on 1-25-16 by medical care provider. Reports of pressure ulcer resolved.</p> <p>The progress lacked further documentation about wound care/prevention.</p> <p>History and physical dated 2-29-16 recorded: Chief complaint: Pressure ulcer follow up. 1. Pressure ulcer restart antiseptic ointment to excoriated are four times a day and with every change of depends.</p> <p>Observation on 8-22-16 at 1:10 p.m. certified staff C transfer resident from wheel chair to toilet. Observed excoriated perineal area. Coccyx red and two centimeter open area noted top right inside buttock. Skin peeling around area. Incontinent care provided and caloseptine cream applied to area. Resident lacked heel protection to protect against pressure ulcers as ordered on 12-28-15.</p>	S5161		

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S5161	<p>Continued From page 14</p> <p>Review of the Medication Administration Record (MAR) lacked documentation for treatment of open wound on right buttock.</p> <p>Interview on 8-24-16 at 10:50 a.m. with licensed nurse B stated and confirmed the NSA/HCS lacked interventions for wound care on buttocks, excoriation, and heel covers on feet to protect against pressure ulcers. Licensed nurse B stated and confirmed resident did not have heel protectors in place.</p> <p>For residents #100, #200, and #300, the operator failed to ensure the NSA contained a description of HCS to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan.</p>	S5161		
S5215 SS=E	<p>26-42-104 (d) Disaster and Emergency Preparedness Education</p> <p>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:</p> <p>(1) Orientation of new employees at the time of employment to the home ' s emergency management plan;</p> <p>(2) education of each resident upon admission to the home regarding emergency procedures;</p> <p>(3) quarterly review of the home ' s emergency management plan with employees and residents; and</p> <p>(4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.</p>	S5215		

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S5215	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3)</p> <p>The facility identified a census of 8 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator failed to conduct a quarterly review of the home's emergency management plan with employees and residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 8-22-16 at 12:50 p.m. reviewed quarterly review of the disaster and emergency management plan with operator. The review lacked documentation for residents. The operator stated he/she misunderstood and only reviewed with employees. <p>For all residents, the operator failed to conduct a quarterly review of the home's emergency management plan with employees and residents.</p>	S5215		
S5251 SS=E	<p>26-42-105 (f) (11) Resident Records 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: KAR 26-42-204(d)</p> <p>The facility identified a census of 8 residents.</p>	S5251		

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S5251	<p>Continued From page 16</p> <p>The sample included 3 residents and 1 focus review. Based on 3 (#100, #200, #300) of 3 residents sampled, the operator failed to ensure 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 taken.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Record review for resident #100 revealed admit date of 5-19-16 with diagnoses atrial fibrillation, rheumatoid arthritis, venous insufficiency, legally blind, anxiety, difficulty walking, and edema. <p>The annual Functional Capacity Screen (FCS) dated 5-19-15 and the significant change FCS dated 4-19-16 recorded resident independent with cognition, communication, required supervision with eating, physical assistance with bathing, dressing, toileting, transfer, walking/mobility, unable to assist with management of medications/treatments, experienced impaired vision due to being legally blind, and falls/unsteadiness.</p> <p>The NSA/HCS dated 4-19-16 recorded physical assistance with shower, dressing, grooming, transfer, ambulation, uses bedside commode, facility staff to administer and manage medications and treatments.</p> <p>The progress notes recorded the following:</p> <p>10-9-15 (no time), resident requested family member to take resident to an emergency room because of hip pain and generalized fatigue. Operator notified for recommendation and was informed resident had been admitted to hospital with diagnosis hematoma of hip and possible</p>	S5251		

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S5251	<p>Continued From page 17</p> <p>anemia.</p> <p>Record lacked documentation of date, signs, symptoms including the time date of occurrence, and results of actions taken.</p> <p>10-12-15 (no time), was notified at 10:30 resident to be discharged from hospital and order for physical therapy and occupational therapy. Activities of ambulation with assistance only and advance as tolerated. To hold coumadin (blood thinner) until 10-19-15 due to abnormal labs.</p> <p>The record lacked date of time.</p> <p>3-9-16 (no time), bruise noted on left arm 20 Centimeters (CM) by 14 CM. Resident on coumadin therapy. Resident had a doctor appointment on 3-10-16 at 2:30 p.m.</p> <p>The record lacked the time, symptoms of injury, other indications of illness, (blood thinner), time of occurrence, actions taken and results of actions taken.</p> <p>4-12-16 (no time) resident had gone to emergency room by family member on 4-4-16 and had partial hip surgery on 4-5-16. Resident transferred from hospital on 4-8-16 to rehabilitation facility.</p> <p>The record lacked documentation of the time, signs/symptoms, and indications of illness/injury prior to 4-4-16 and lacked documentation of actions taken and results of actions taken.</p> <p>4-19-16 (no time) Resident re-admitted to facility from rehabilitation hospital. Resident to receive physical therapy evaluation. Vital signs blood pressure 128/90, pulse 90, respirations 20,</p>	S5251		

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S5251	<p>Continued From page 18</p> <p>temperature 95.7.</p> <p>The record lacked the time resident returned from the rehabilitation hospital and any signs/symptoms of pain, illness or injury.</p> <p>No further documentation in progress notes until:</p> <p>5-5-16 (no time) blood drawn for INR. Results 3.6 (high). Hold coumadin today and restart tomorrow.</p> <p>The progress notes lacked documentation of an injury where resident fell on walker causing a chest contusion. The faxed medical care provider orders dated 8-2-16 recorded, "breast contusion from fall". The emergency room visit from hospital dated 7-20-16 recorded resident had a chest contusion.</p> <p>Interview on 8-23-16 at 10:45 a.m. with licensed nurse B stated, "Documented large bruise on left arm and did not recall how he/she became aware of the bruise. I did not document complaint of hip pain nor when resident complained of pain in left arm. Licensed nurse B also stated and confirmed the record lacked documentation when resident fell onto walker and had dark bruising under chin and across chest. Resident was diagnosed with a contusion on chest after went to the emergency room. When resident returned from the hospital I did not observed incision site from partial hip replacement."</p> <p>Interview on 8-23-16 at 1:20 p.m. with resident #100 stated, "He/She had a large bruise on left arm and thought it was from a family member assisting him/her into a car. I had pain in my right hip for a while and decided he/she should go to the emergency room. At the emergency room</p>	S5251		

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S5251	<p>Continued From page 19</p> <p>found out he/she had a broken hip and had a partial hip repair. I then went from hospital to a rehabilitation facility then back home to this facility. I did fall on my walker hit my chin and chest on my walker. I do not recall the date but had dark bruising from neck and across chest from what a family member told me.</p> <p>- Record review for resident #200 revealed an admit date of 3-11-14 with diagnoses of dementia with behaviors and hypothyroidism.</p> <p>The annual FCS dated 11-18-15 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, communication, unable to assist with management of medications/treatments, bladder incontinence, experienced short term memory loss, memory recall, long term memory loss, decision making, impaired decision making, and fall/unsteadiness. Resident does not speak English.</p> <p>The annual NSA/HCS dated 11-18-15 recorded resident #200 required total assistance for eating/feeding pureed diet, one person physical assistance with bathing, dressing, grooming, transfers, ambulation short distance, use wheel chair for long distance, physical assistance with toileting, repositioning, body alarm when in bed, facility staff to administer medications/treatments as ordered by medical care provider.</p> <p>The progress notes recorded:</p> <p>8-17-16 (no time) Resident had sustained an injury to right index finger during the night of 8-15-16 at 1:30 a.m. Informed the medical care provider, family came and took resident to</p>	S5251		

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S5251	<p>Continued From page 20</p> <p>immediate medical care. Resident had multiple steri-strips applied and wrapped hand with ace wrap.</p> <p>The record lacked documentation of the time of the incident, signs/symptoms of injury, actions taken and results of actions taken.</p> <p>8-22-16 medical care provider orders to consult home health to provide wound care, cleanse finger/wound with betadine, pat dry with gauze, cover with xeraform dressing and gauze, kerlix or wrap with ace wrap three times a week.</p> <p>8-22-16 at 1:25 p.m. observed licensed nurse B remove dressing from right hand index finger. Observed one and one half inch tear on finger from base of finger to knuckle. Several steri-strips in place. The tear on right index finger red around site. Finger splint replace and wrapped with ace wrap. Sock applied over right had to keep resident from pulling at dressing.</p> <p>Interview on 8-24-16 at 10:25 p.m. with licensed nurse B stated and confirmed dressing change to right index finger not documented.</p> <p>For resident #100, the record lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken and results of actions taken.</p> <p>- Record review for resident #300 revealed an admit date of 6-7-14 with diagnoses of dementia with behaviors, hypertension, dyskinesia, hypothyroidism, depression, and anxiety.</p> <p>The FCS dated 1-21-16 recorded resident unable to assist with bathing dressing, toileting, transfer,</p>	S5251		

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S5251	<p>Continued From page 21</p> <p>walking/mobility, eating, management of medications/treatments, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, and impaired decision making.</p> <p>The NSA/HCS dated 1-20-16 recorded resident total assist with feeding pureed diet, facility management of medication administration and treatments administer as ordered by medical care provider. Resident required physical assistance with bathing, dressing, grooming, transfers, non-ambulatory, toileting, and oral care. Hospice services as ordered.</p> <p>The progress notes recorded the following:</p> <p>1-19-16 (no time) new order from hospice for stage two wound to left buttock. Clean with wound cleanser, apply medi honey to wound bed, cover with opti foam and change every seven days.</p> <p>The record lacked documentation of the time, signs/symptoms of wound, actions taken and results of actions taken.</p> <p>History and physical dated 2-29-16 recorded: Chief complaint: Pressure ulcer follow up. 1. Pressure ulcer restart antiseptic ointment to excoriated are four times a day and with every change of depends.</p> <p>Observation on 8-22-16 at 1:10 p.m. certified staff C transfer resident from wheel chair to toilet. Observed excoriated perineal area. Coccyx red and two centimeter open area noted top right inside buttock. Skin peeling around area. Incontinent care provided and caloseptine cream applied to area. Resident lacked heel protection</p>	S5251		

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S5251	<p>Continued From page 22</p> <p>to protect against pressure ulcers as ordered on 12-28-15.</p> <p>Review of the Medication Administration Record (MAR) lacked documentation for treatment of open wound on right buttock.</p> <p>Interview on 8-24-16 at 10:50 a.m. with licensed nurse B stated and confirmed the record lacked documentation of treatment to open wound on buttock.</p> <p>For residents #100, #200, and #300, the operator failed to ensure documentation of all incident, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken and results of actions taken.</p>	S5251		