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	N067010	A. BUILDING: _____ B. WING _____	02/01/2022

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COUNTRY PLACE SENIOR LIVING OF CHANUTE	701 OSA MARTIN BLVD CHANUTE, KS 66720

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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey with complaint investigation #164630 conducted on 01/26/22, 01/27/22, 01/31/222 and 02/01/22.	S 000		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-204 (a) The facility reported a census of 28 residents. The sample included 3 residents and 2 focused review residents. Based on observation, interview and record review the facility failed to ensure a Licensed Nurse (LN) provided or coordinated the provision of necessary health care services to meet the needs for one of five residents (R) R213 regarding a reddened scratch like skin condition first noted on 12/31/21 which worsened to an open area with slough on 01/11/22, and further worsened to necrotic tissue noted on 01/27/22 without evidence of a LN evaluation, development, and implementation of interventions to promote healing.	S3155		

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

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S3155	Continued From page 1 Findings included: - Record review for R213 revealed an admission date of 11/27/19 with diagnoses of dementia, depression, anxiety, and hypertension. The "Significant Change Functional Capacity Screening" (FCS) dated 09/08/21 identified the resident with cognitive impairment in all aspects and impaired ability to communicate marked as sometimes understandable and understands. She was at risk for falls with impaired decision making. The FCS required total assistance for bathing and mobility. She required physical assistance with dressing, toileting, transfers, eating, and management of medications or treatments. The "Negotiated Service Agreement/Health Care Plan" (NSA/HCP) dated 09/08/21 directed staff to provide total assistance with bathing twice a week and as needed (PRN). R213 required full assistance with dressing by staff, she refuses to use the toilet which results in total incontinence of bowel and bladder. She needs full assistance of one staff for transfers and utilized a wheelchair propelled by staff for mobility. The NSA/HCP directed staff to administer all medications and treatment per a medical care provider's order. The only revision to the NSA/HCP dated 11/01/21 indicated a change in the nurse responsible for implementation of the nursing care to LN A. On 01/26/22 at 03:30 PM LN A provided the resident roster and R213 was marked with a skin condition. LN A reported the resident had a pressure ulcer due to the resident laying on her preferred side to sleep. LN A reported she had contacted an outside provider to provide wound management.	S3155		

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S3155	Continued From page 2 Review of the documents titled, "Resident Progress Notes" revealed the last entry dated 10/05/21 at 05:30 PM. LN A provided documents titled, "Shower Skin Sheet" for R213 with one dated 12/30/21, which indicated the resident had no skin issues. The next sheet dated 01/12/22 included "No new skin issues, still has open wound on right hip and already being treated." Both sheets were signed by LN A and she confirmed there were no "Shower Skin Sheets" between those two. Not available in the chart at the time of the review and provided by LN A on 01/27/22 was a document titled, "Physician Appointment Form" dated 01/07/22. The document directed to consult with a home health provider to assist with wound management, start with honey alginate, covered with gauze, secured with medipore tape and cover with ABD (a non-woven thick absorbent dressing), off load patient off right hip and padding as needed in wheelchair. The document was signed at the bottom by LN A. The medical care provider's order for the wound dressing lacked directions of how often to change the dressing and LN A failed to clarify the order. The "Visit Note Report" from the outside provider dated 01/11/22 at 01:12 PM indicated the onset of service as of 01/11/22. The resident had an open area on her right hip which measured 1.2 cm (centimeters) length, 0.6 cm width and 0.2 cm depth full thickness with irregular edges, and serosanguinous (thin watery fluid pink in color due to presence of small amounts of red blood cells). The wound did not have necrotic tissue (non-viable tissue) and the area was not painful for the resident. The "Visit Note Report" indicated	S3155		

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S3155	Continued From page 3	S3155		

the resident's wound care included to cleanse with normal saline, pat dry, apply honey alginate, cover with gauze, secure with ABD pad, and Medipore tape. Facility staff were to change the dressing daily and the outside provider would monitor the area weekly.

The 01/18/22 "Visit Note Report" at 03:06 PM indicated measurements were not due, had the same wound description, and indicated the resident had some pain and tenderness at the wound site.

The "Visit Note Report" on 01/26/22 at 01:45 PM had no measurements for the wound and under depth description it indicated the wound was necrotic.

The "Visit Note Report" dated 01/28/22 at 11:39 AM reflected a change in wound classification to suspected deep tissue injury.

Review of the January 2022 medication administration record/treatment record (MAR/TAR) revealed an entry, which began on 01/17/22 to offload resident off of the right hip with padding in the wheelchair PRN and a time of per shift with three times listed.

Observation on 01/26/22 at 04:15 PM revealed R213 seated in a wheelchair in her room with the TV playing. She did not communicate when conversation attempted and repeatedly said "I don't know". She wore a gown which was up around her hips with her legs bare and a lap blanket rested on the floor beside her. The wheelchair lacked any extra seat cushions or padding.

Observation on 01/27/22 at 09:24 AM revealed

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Certified Nursing Aide (CNA) B and CNA C entered R213's room to get her up for the day. The resident laid mostly on her right side with a small wedge positioning cushion under her right lower abdomen. CNA B said they used the wedge to try to keep her off the right hip. When they turned her to the left side observation revealed an ABD pad on the right hip with the tape partially coming off. Neither the pad or tape was dated to indicate when it was placed. The pad had visible dark drainage from the center outward approximately 6 cm circular. CNA B reported an outside provider came once a week to change the dressing, which was yesterday. She did not know whether the facility nurse changed the dressing or not. She said the last time she saw the area it was really red, but not open. She was not sure of the date. LN A was summoned to the room and she reinforced the dressing with directions to staff she would change it after lunch when the resident laid down again. When LN A palpated the dressing to evaluate the drainage the resident cried out in pain. LN A reported she was first aware of the skin issue on 12/31/21 and it was reddened with what looked like a small scab scratch. CNA B and C assisted the resident to the wheelchair at about 09:45 AM. The wheelchair lacked any cushion or additional padding.

Observation on 01/27/22 at 11:45 AM revealed the resident remained in her wheelchair in the room and CNA B reported she should get repositioned every 2 hours. CNA B went to LN A to inquire if she was ready to complete the dressing change. Upon arrival to the room the resident remained in the wheelchair and was served the noon meal. At 01:20 PM CNA B and CNA D entered R213's room to assist her from the wheelchair to the bed. They positioned the resident on her left side by placing the wedge

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cushion to her lower back. At 01:35 PM LN A and LN E entered the room to change the wound dressing. The wound bed was completely covered in dark colored necrotic eschar tissue, the surrounding skin was fiery red, and the resident cried out in pain when the wound was touched. LN A guessed at the size to be 2-3 cm length and 1.5 cm width. When asked how often the dressing was changed, she said every other day and PRN.

Interview on 01/27/22 at 10:00 AM with LN A confirmed staff alerted her to R213's skin issue on 12/31/21. She said she looked at the area and described it as reddened with a small scratch like scab in the center. She did not test the area to determine if the skin was blanchable (redness doesn't fade when pressure is applied) and confirmed she failed to make a "Resident Progress Note" about the altered skin condition. She confirmed no changes were made to the residents NSA/HCP to address the altered skin condition. She could not recall when she next saw the resident's altered skin condition and reported she put a dressing on it for protection. She reported staff had her look at R213's skin on the right hip on 01/06/22 and it was open with a pink wound bed and yellow slough forming. She did not have any measurements for the area and confirmed the "Resident Progress Notes" lacked information about the altered skin condition. She had the medical care provider who comes every week look at it and he wrote orders on 01/07/22. She reported contacting the outside provider and they first came on the 01/11/22. When asked about dressing changes by the facility licensed nurse LN A said there was a dressing on the area for protection. LN A said the last time she saw the wound was on 01/25/22 when the resident had pulled the dressing off and she said the wound

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S3155	Continued From page 6 looked the same as previous observation without any drainage. She confirmed the NSA/HCP lacked any revision as of 01/27/22 to address the resident's altered skin condition. The facility failed to ensure a licensed nurse (LN) provided or coordinated the provision of necessary health care services to meet the needs for one of five residents (R) R213 regarding a reddened scratch like skin condition first noted on 12/31/21 which worsened to an open area with slough on 01/11/22 and further worsened to necrotic tissue noted on 01/27/22 without evidence of a LN evaluation, development and implementation of interventions to promote healing.	S3155		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S3200		

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S3200	Continued From page 7 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 28 residents (R). The sample included three R for facility managed medications. Based on record review and interview the facility failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for two of three sampled residents (#226 and #303) Findings included: - Record review for R226 revealed an admission date of 10/16/15 with diagnoses of diabetes mellitus type two and osteoarthritis. The functional capacity screen dated 02/01/21 identified the resident with impaired decision making and needed physical assistance with medication management and unable to perform any task of treatments. The negotiated service agreement/health care plan dated 02/01/21 directed facility staff to administer to administer medications as ordered by physician and to see the MAR. On 01/27/22 at approximately 12:30 PM licensed nurse (LN) E provided a copy of orders she received by fax on 01/27/22 at 12:09 PM. She said the medial care provider sent the orders over as a recapitulation of orders. A comparison of those orders to the January 2022 medication administration record (MAR) revealed the following discrepancies:	S3200		

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S3200	Continued From page 8 Potassium Chloride 10 milliequivalents (mEq), extended release tablets on the orders directed to give two by mouth twice a day (BID) (total of 40 mEq daily) and the MAR had potassium chloride 10 mEq (did not specify extended release) take two capsules by mouth every day (total of 20 mEq). The orders had two listing for Metoprolol 12.5 mg BID and 25 mg BID. The MAR only had 25 mg BID. The MAR had Lyrica (pregabalin) 50 mg at HS (hours of sleep) but the orders were pregabalin 25 mg BID. The orders included vitamin D (no strength) take one tab every day and the MAR had vitamin D 5000 one tablet BID. Bumetanide orders do not match the MAR. The orders directed for one milligram (mg) tablets give four tablets by mouth daily in the morning with another order for bumetanide two mg tablets give two tablets every day. The MAR had one entry for bumetanide four mg tablets give two tablets by mouth every AM. The MAR had an entry for Xanax 0.5 mg one tablet a day PRN four hours between dosages and this was not n the orders. Diclofenac 1% topical gel on the orders to apply 4-5 grams to affected area every four hours as needed (PRN) and the MAR had Voltaren (diclofenac) gel two grams to shoulders, hips and knees every six hours on schedule. Ketoconazole 2% topical cream on the orders to	S3200		

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S3200	Continued From page 9 apply to wound on buttock and under abdominal fold twice daily for seven days at a time. The MAR had mix ketoconozole/mupricocin, apply under folds when red PRN. The orders included mupirocin 2% topical ointment apply to dry feet around toe nails twice daily after Epsom salt soak. This order was not on the MAR. The MAR had an entry to use an additional Voltaren gel PRN but not on the orders Afrin nasal spray appeared on the orders but not on the MAR The orders included Nyamyc (nystatin anti-fungal) 100,000 unit/gram topical powder with directions to apply to affected area three times a day for seven days with a state date of 04/17/20. The MAR had Nystatin Powder to abdominal folds, under arm & breast when yeast is present BID until healed. The MAR had entry for PRNs of Refresh Optive gel, Saline nasal spray and Imodium with none of them being on the orders. Interview on 02/01/22 at 02:00 PM administrative staff M and LN A confirmed the discrepancies in the orders, they had contacted the medical care provider and are awaiting directions. The facility's 2015 policy titled, "Medication Management" directed a licensed nurse conducts a monthly review of each resident's MAR whose medications are managed by the residence. Any variances identified in the review will be reported to the resident's physician.	S3200		

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S3200	Continued From page 10 The facility failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for R226. - Record review for R303 revealed an admission date of 03/13/15 with diagnoses of hypertension, gait imbalance, osteoporosis, osteoarthritis and fibromyalgia. The functional capacity screen dated 01/07/21 identified the resident with impaired short-term memory, memory/recall and decision making. She needed physical assistance with medication and treatment management. The negotiated service agreement/health care plan dated 01/07/21 directed staff to administer medications as ordered by a physician and to see the medication administration record (MAR). Record review comparison of the recapitulation of orders provided by the Hospice outside provider and dated 01/13/22 when compared to the January 2022 MAR revealed the MAR had an entry for GenTeal 0.5 inch strip to each eye at HS (hours of sleep) which was not on the current orders. The MAR included staff initials to indicate the medication was administered on all days from 01/13/22 through 01/26/22. An electronic interview on 02/01/22 at 12:16 PM with administrative staff M confirmed the discrepancy regarding the GenTeal and the medication was discontinued. The facility's 2015 policy titled, "Medication Management" directed a licensed nurse conducts a monthly review of each resident's MAR whose	S3200		

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S3200	Continued From page 11 medications are managed by the residence. Any variances identified in the review will be reported to the resident's physician. The facility failed to ensure licensed nurses and certified medication aides administered facility managed medications in accordance with a medical care provider's written order and professional standards of practice for R303.	S3200		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d)(4) The facility reported a census of 28 residents and managed the medications for 26 of those residents. The facility identified three residents who received insulin by injector pens which the certified medication aide (CMA) would prepare and dial the dose. The facility identified six currently employed CMAs. Based on record review and interview the facility failed to ensure a licensed nurse oriented and instructed six out of six CMAs in the performance of blood sugar testing, dialing the prescribed dose of insulin by injector pen(s) for the resident to inject. The administrator further failed to ensure documentation of the CMA's demonstration of competency signed by the nurse and the CMA in	S3202		

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S3202	Continued From page 12 each employee's personnel record (CMA F, G, H, J, K and L). Findings included: - On 01/26/22 licensed nurse (LN) A provided a resident roster which identified three of the 26 residents who had facility management of medications also received routine blood sugar testing and insulin by an insulin injector pen. During the entrance conference administrative staff M reported the facility CMAs were expected to perform blood sugar testing for residents, preparation of the insulin injector pens including dialing of the prescribed dose. The resident would then inject the medication into the subcutaneous tissue. During personnel record review on 01/27/22 administrative staff M failed to provide evidence of the CMAs being oriented and instructed in the performance of blood sugar testing, preparation of the insulin pens and dialing the prescribed dose. Interview on 01/27/22 at 10:00 AM LN A confirmed the currently employed CMAs lacked orientation and instruction on blood sugar testing and insulin pens. She reported she assumed they had training from the previous LN, she had a form to review with them and have them sign but had not gotten to it yet. The facility failed to ensure a licensed nurse oriented and instructed six out of six CMAs in the performance of blood sugar testing, dialing the prescribed dose of insulin by injector pen(s) for the resident to inject. The administrator further failed to ensure documentation of the CMA's	S3202		

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S3202	Continued From page 13 demonstration of competency signed by the nurse and the CMA in each employee's personnel record (CMA F, G, H, J, K and L).	S3202		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.	S3215		

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S3215	Continued From page 14 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h)(4) The facility reported a census of 28 residents with a licensed capacity for 34 residents. Based on observation, record review and interview the facility failed to ensure licensed nurses and certified medication aides could not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated Tuberculosis (TB) testing solution used for residents and staff. Findings included: - On 01/26/22 administrative staff M reported a census of 28 residents and they had the ability to admit 6 more. Observation on 01/26/22 at 03:48 PM with licensed nurse A revealed an open bottle of TB testing solution in the refrigerator kept in the nursing office. She confirmed the bottle lacked a date and it should be dated to ensure was used within 30 days. The FDA (Federal Drug Administration) tuberculosis (tubersol) package insert directed the tubersol testing solution would expire 30 days after the date of opening. The facility failed to ensure licensed nurses and certified medication aides could not administer medications beyond the manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated	S3215		

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S3215	Continued From page 15 Tuberculosis (TB) testing solution used for residents.	S3215		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (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 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f)(11) The facility reported a census of 28 residents. The sample included three residents (R) and two focused review residents. Based on interview and record review the administrator failed to ensure the 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 were documented for three out of five sampled residents (#213, #303 and #318). Findings included: - Record review for R213 revealed an admission date of 11/27/19 with diagnoses of dementia, depression, anxiety, and hypertension. The "Significant Change Functional Capacity Screening" (FCS) dated 09/08/21 identified the resident with cognitive impairment in all aspects and impaired ability to communicate marked as	S3261		

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sometimes understandable and understands. She was at risk for falls with impaired decision making. The FCS required total assistance for bathing and mobility. She required physical assistance with dressing, toileting, transfers, eating, and management of medications or treatments.

The "Negotiated Service Agreement/Health Care Plan" (NSA/HCP) dated 09/08/21 directed staff to provide total assistance with bathing twice a week and as needed (PRN). R213 required full assistance with dressing by staff, she refuses to use the toilet which results in total incontinence of bowel and bladder. She needs full assistance of one staff for transfers and utilized a wheelchair propelled by staff for mobility. The NSA/HCP directed staff to administer all medications and treatment per a medical care provider's order. The only revision to the NSA/HCP dated 11/01/21 indicated a change in the nurse responsible for implementation of the nursing care to LN A.

On 01/26/22 at 03:30 PM LN A provided the resident roster and R213 was marked with a skin condition. LN A reported the resident had a pressure ulcer due to the resident laying on her preferred side to sleep. LN A reported she had contacted an outside provider to provide wound management.

Review of the documents titled, "Resident Progress Notes" revealed the last entry dated 10/05/21 at 05:30 PM.

Review of the medical provider order section of current orders revealed a fax dated 10/14/21 for a Z-pack antibiotic, portable chest X-ray and portable pelvis with bilateral hips X-ray status post fall. The "Resident Progress Notes" lacked

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S3261	Continued From page 17 information about a fall. On 01/26/22 at 03:30 PM licensed nurse (LN) A provided the resident roster and R213 was marked with a skin condition. LN A reported the resident had a pressure ulcer due to the resident laying on her preferred side to sleep. LN A reported she had contacted an outside provider to provide wound management. LN A provided documents titled, "Shower Skin Sheet" for R213 with one dated 12/30/21, which indicated the resident had no skin issues. The next sheet dated 01/12/22 included "No new skin issues, still has open wound on right hip and already being treated." LN A provided documents she obtained from the outside provider after 01/27/22 which included "Visit Note Report" from the outside provider dated 01/11/22 at 01:12 PM indicated the onset of service as of 01/11/22. The resident had an open area on her right hip which measured 1.2 cm (centimeters) length, 0.6 cm width and 0.2 cm depth full thickness with irregular edges, and serosanguinous (thin watery fluid pink in color due to presence of small amounts of red blood cells). The wound did not have necrotic tissue (non-viable tissue) and the area was not painful for the resident. The "Visit Note Report" indicated the resident's wound care included to cleanse with normal saline, pat dry, apply honey alginate, cover with gauze, secure with ABD pad, and Medipore tape. Facility staff were to change the dressing daily and the outside provider would monitor the area weekly. Observation on 01/27/22 at 01:35 PM LN A and LN E entered the room to change the wound dressing. The wound bed was completely	S3261		

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covered in dark colored necrotic eschar tissue, the surrounding skin was fiery red, and the resident cried out in pain when the wound was touched. LN A guessed at the size to be 2-3 cm length and 1.5 cm width.

Interview on 01/27/22 at 10:00 AM with LN A confirmed staff alerted her to R213's skin issue on 12/31/21. She said she looked at the area and described it as reddened with a small scratch like scab in the center. She did not test the area to determine if the skin was blanchable (redness doesn't fade when pressure is applied) and confirmed she failed to make a "Resident Progress Note" about the altered skin condition. She could not recall when she next saw the resident's altered skin condition and reported she put a dressing on it for protection. She reported staff had her look at R213's skin on the right hip on 01/06/22 and it was open with a pink wound bed and yellow slough forming. She did not have any measurements for the area and confirmed the "Resident Progress Notes" lacked information about the altered skin condition.

Electronic interview with administrative staff M on 01/31/22 at 04:55 PM confirmed the "Resident Progress Notes" lacked documentation of the incident with the fall, X-rays and her skin condition.

The administrator failed to ensure the 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 were documented for R213's fall, X-rays, and skin condition.

- Record review for R303 revealed an admission date of 03/13/15 with diagnoses of hypertension,

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gait imbalance, osteoporosis, osteoarthritis and fibromyalgia.

The functional capacity screen dated 01/07/21 identified the resident with impaired short-term memory, memory/recall and decision making. She needed physical assistance with bathing, dressing, eating and supervision with walking/mobility.

The negotiated service agreement/health care plan dated 01/07/21 directed staff to provide assistance with showers and dressing with supervision for transfers and toileting.

Review of the "Resident Progress Notes" revealed a single page document starting 08/18/20 with the last entry 02/19/21 at 10:00 AM. There were two pages titled, "Monthly Summary" dated 07/02/21 and 09/30/21.

Review of the medical care provider current orders section revealed a "Physician Appointment Form" dated 05/12/21 which included Macrobid 100 milligrams (mg) twice a day for 10 days to treat a urinary tract infection (UTI). The "Resident Progress Notes" lacked any information to indicate the resident had symptoms of illness, monitoring of the resident while receiving treatment and results of the treatment. A fax from the medical care provider on 12/06/21 included an order for nitrofurantoin 100 mg by mouth twice a day for 10 days to treat a UTI and repeat urinalysis after the antibiotic. The "Resident Progress Notes" lacked any documentation of symptoms, monitoring during treatment and results of the treatment.

Interview with licensed nurse D on 01/27/22 at 11:45 AM confirmed the "Resident Progress

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Notes" lacked documentation of these illness.

The administrator failed to ensure the 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 were documented for R303 recurrent urinary tract infections.

- Record review for R318 revealed an admission date of 06/22/21 with diagnoses of dementia with behavioral disturbances, hypertension, unspecified dizziness and giddiness.

The functional capacity screen dated 08/16/21 identified the resident with impaired cognition in all aspects and needed physical assistance with all activities of daily living (ADL). He was not marked for having socially inappropriate behaviors.

The negotiated service agreement/health care plan dated 08/16/21 directed staff to provide assistance with all ADLs. For toileting it indicated the resident had an indwelling urinary catheter since 08/14/21 due to bladder spasms.

Review of the "Resident Progress Notes" revealed two pages of notes between 08/06/21 at 05:30 PM and 10/06/21 at 02:00 PM with an additional document titled "Monthly Summary" dated 09/30/21. On 06/22/21 licensed nurse (LN) N made an entry on a document titled, "Skin Condition Assessment" which indicated the resident had skin tear on his right forearm and scratches on his calves from dry skin. This document failed to include any information about actions taken or results of those actions. The section of the document for "Weekly Evaluation" included an entry dated 07/01/21 which continued

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S3261	Continued From page 21 to reflect scratches on ankles and calves with no indicator of actions taken. Review of the medical care provider current orders section revealed a document titled, "Nursing Home/Assisted Living Discharge Nursing Summary Note" dated 08/22/21 which indicated the resident had a hospital stay starting on 08/19/21. The "Resident Progress Notes" revealed an entry dated 08/12/21 at 10:30 AM with no indicator of a need for hospitalization. The next entry was dated 09/09/21 at 11:00 AM. On 08/23/21 a medical care provider ordered to place an indwelling urinary catheter if the R318 was unable to void. The "Resident Progress Notes" lack any information about the resident's ability to void or not and whether he needed the catheter or not. The resident went in and out of the hospital between 09/09/21 and 10/05/21 which the "Resident Progress Notes" reflected. An entry dated 10/05/21 at 11:00 AM indicated the resident returned at this time on Hospice services for continued syncope, lactic acidosis and urinary tract infections. The next and last entry dated 10/06/21 at 02:00 PM included R318 had slept all day will open his eyes to his name. Record review revealed a document titled, "Report of Resident Death" which indicated the resident died on 10/12/21 at 10:50 AM. The "Resident Progress Notes" lacked any information on the resident's condition between 10/06/21 and 10/12/21 or events of his death. Electronic interview on 01/31/22 at 03:37 PM with administrative staff M confirmed the "Resident Progress Notes" provided were all she found. The administrator failed to ensure the documentation of all incidents, symptoms, and	S3261		

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S3261	Continued From page 22 other indications of illness or injury including the date, time of occurrence, action taken, and results of the action were documented for R318 regarding skin conditions, illness, hospitalization, urinary status/catheter insertion and event leading to death.	S3261		