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	B087153	A. BUILDING: _____ B. WING _____	C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORD SENIOR CARE INC - ROCKWOOD	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 a complaint (#141915, #143351, #145872) at the above named home plus facility conducted on 9/18,19,20,23,24/2019.	S 000		
S5026 SS=D	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(A) The facility reported a census of 8 residents. The sample included 3 residents and 2 closed record reviews. Based on record review and interview for 1 (#948) of 3 sampled resident, the operator failed to ensure a cognitively impaired resident was not subjected to abuse when facility staff restrained the resident by sitting the resident in a recliner chair with the feet elevated and the resident not able to lower the foot rest in order to get up out of the chair and walk independently. Findings included: - Record review for Resident #948's revealed the resident admitted to the facility on 3-26-19 with	S5026		

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

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diagnoses of hypertension, major depression, glaucoma, and Alzheimer.

The Functional Capacity Screed dated 3-26-19 revealed the resident was independent with transfers and walking and had impaired cognition with impaired decision making abilities.

The Negotiated Service Agreement dated 8-18-19 revealed the resident required partial assist with transfers and ambulation.

Observations on 9-19-19 from 7:49 Am to 12:11 PM revealed the following:
7:34 AM the resident sat in a recliner with the foot rest elevated. The resident scooted self to the edge of the chair and stood up out of the recliner and walked over to the TV. Certified staff B went to the resident and took her back to the recliner and raised the feet and lowered the head more than before and sit while she cooked breakfast. The resident sat and then fidgeted in the chair. Certified staff B turned off the bright light and proceeded to prepare breakfast.
7:38 AM - the resident kept trying to get up and stated "I can't do it" and started to make a crying sound then said "I can't get it out".
7:42 AM - the resident leaned forward and certified staff B told the resident to sit back. The resident sat back a few minutes then leaned forward trying to scoot to the edge of chair and lift her legs over the side of the chair.
7:49 AM - The resident sat in recliner with feet elevated and started to fidget and had both legs over the side of the chair trying to get up out of the chair. Certified staff B saw the resident and moved the resident's feet back onto the foot rest and told the resident they would eat breakfast

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S5026	Continued From page 2	S5026		

soon. The resident leaned back in the chair and closed her eyes.
7:51 AM - the resident became restless and kept leaning forward trying to scoot forward in the chair and move her legs to get up. The resident was able to lift her left leg and scoot to the edge of the chair, foot rest remained elevated, and stated "Take it, take it now". Certified staff B kept telling the resident to sit back in the chair each time the resident tried to get up.
7:55 AM - Certified staff B went over to the resident again and told her to lean back in the chair and relax. As soon as certified staff B walked away the resident tried to get out of the chair. The resident had a furrowed brow and frustrated facial expressions and said "come on", Oh heck, she's crying".
8:00 AM - The resident remained in the recliner chair with feet elevated, fidgety and stated "Don't cuss me out. From the kitchen certified staff B told the resident not to talk like that and sit back and relax. The resident kept leaning forward and trying to get up and certified staff B kept telling the resident to lean back.
8:05 AM- the resident tried to get up, both legs were over the side of the foot rest. Certified staff B came out of the kitchen and lowered the foot rest and assisted the resident to walk over to the table for lunch.
8:29 AM certified staff D held the resident's hand and assisted her to stand up and walk to a rocking chair.
10:25 AM - the resident had sat in the rocking chair calmly without trying to get up. Hospice staff came to facility and assisted the resident to shower and then sat the resident in the recliner with her feet elevated.
12:11 PM the resident scooted to the end of the

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S5026	Continued From page 3 recliner with the foot rest elevated and after a couple of tries the resident stood and walked over to another chair. Operator staff A quickly came to the resident and assisted her back to the recliner. During an interview on 9-19-19 at 7:36 AM certified staff C reported the resident had not fallen except for one other time when she was pushing the table. On 9-19-19 at 1:12 PM when asked why staff did not let the resident walk around the facility independently certified staff B reported the resident wanders and gets into things and into other residents rooms at times. Staff B confirmed the resident could walk without staff assistance. For Resident #948, the operator failed to ensure the cognitively impaired resident was not subjected to abuse when facility staff restrained the resident by sitting the resident in a recliner chair with the feet elevated and the resident was not able to lower the foot rest in order to get up out of the chair and walk independently	S5026		
S5156 SS=F	26-42-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement.	S5156		

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S5156	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-42-102(b) The facility reported a census of 8 residents. The sample included 3 residents and 2 closed records. Based on record review and interview, the operator failed to ensure direct care staff or licensed nursing staff were responsive at all times when the only certified staff on duty went outside to smoke and left all residents unattended. Findings included: - Facility staff provided resident roster for 8 residents on 9-23-19. The roster revealed 6 residents with cognitive impairment. Record review for resident # 958 revealed admission date of 7/11/19 with diagnosis of high blood pressure, chronic kidney disease, diabetes mellitus two, legally blind and peripheral vascular disease. The admission functional capacity screening (FCS) dated 7/9/19 identified the resident required health care services. She was recorded to have impaired vision but did not use assistive devises. The negotiated service agreement (NSA) dated 7/9/19 directed staff to provide a diabetic diet, assist with bathing and dressing/undressing. Staff to give partial assist with ambulation and toileting. The health care plan (HCP) dated 7/11/19 recorded resident was alert and oriented, she uses a walker and wheel chair for mobility, and	S5156		

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S5156	Continued From page 5	S5156		

she was a fall risk. The plan recorded assist with all transfers and ambulation.

Record review completed on 9/23/19 revealed nurses notes as follows:
On 9/15/19, no time noted, witnessed fall in kitchen. VS respirations 16, blood pressure 138/79, Temperature 97.9 and pulse 80. Complained of left ankle pain: does not want to call an ambulance and states (family member) cannot take her to the emergency room (ER) due to (her) bad legs too; call to (family member) and PACE provider placed. Dr Mohdi returned call with new orders.
Note dated 9/15/19 at 6:30 PM ...Continues to state she did not want to go to the ER: Left ankle ROM normal and able to wiggle toes: does not want to stand on it because it is sore: assisted by CMA to bed with left leg elevated and ice applied as ordered. Instructed to have aide call nurse if pain worsened: verbalized understanding.

Physicians orders dated 9/15/19 recorded Left ankle pain: rest, ice x 20 min and elevation, make appointment to be seen on 9/16/19 at PACE provider.
9/15/19 Resident elected to go to ER due to increasing pain. To transport to hospital ER per choice.
Note dated 9/15/19 at 9:58 PM Received call from certified nurse aide that residents pain got worse and she called PACE provider and they called an ambulance. 10:03 spoke with registered nurse at (hospital) states he will call upon final diagnosis. 10:22 PM received call that resident was being admitted for suspected fracture.

An interview on 9-23-19 at 11:52 am with Operator

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S5156	Continued From page 6 #A confirmed the following staffing pattern: "the facility has 2 staff during supper then after supper we have 1 staff from 7 -11 pm, and then from 11 pm to 7 am we have a sleeper in the house." Operator #A revealed that Resident #958 had a witnessed fall on 9-15-19. Resident was able to stand but did not want to put pressure on her left foot. The resident called her PACE provider from her cell phone and then the PACE provider called EMS (Emergency Management Services). When EMS showed up, the resident answered the door and the aide was outside smoking. EMS took the resident to the hospital. The Operator stated the employee was terminated (on 9-15-19 at 11:05 pm) after the incident. Operator stated house policies are that staff are not to go outside of the facility, "I go through the rules as to that they are not to smoke outside." Stated she will be reeducating all staff on policies regarding staff inside the house at all times and the no smoking policies. Text message was sent to all employees regarding no smoking on the back patio at all. The facility failed to provide a written policy outlining staff rules. For all residents, the operator failed to ensure direct care staff were responsive at all times.	S5156		
S5251 SS=E	26-42-105 (f) (11) Resident Records 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.	S5251		

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S5251	Continued From page 7	S5251		

This REQUIREMENT is not met as evidenced by:
KAR 26-42-105(f)(11)

The facility reported a census of 8 residents. The sample included 3 residents and 2 closed record reviews. Based on interview and record review the operator failed to ensure the record contained documentation of all incidents, symptoms, and other indications of illness or injury for 2 (#918, #928,) of 3 sampled residents.

Findings included:

- Review of the resident # 918's medical record revealed he/she admitted to the facility on 4-27-19 with diagnoses of dementia, congestive heart failure, gout and chronic edema.

Review of the resident's functional capacity screen dated 4-27-19 revealed the resident required supervision with bathing, dressing, toileting and independent with transfers and walking. The resident had bladder incontinence and was alert and oriented.

Review of the resident's negotiated service agreement dated 4-27-19 revealed staff provided assistance with bathing, dressing, transfer and ambulation assistance.

Review of the resident's record included a physicians fax order to send resident to local hospital due to fall.

Review of the resident's nurses notes revealed an entry dated 5-15-19 that the resident readmitted

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S5251	Continued From page 8 form the hospital due to a left hip repair. The record lacked information as to what, where, or when something happened which resulted in the resident going to the hospital prior to 5-15-19. - Review of resident #928's medical record revealed he/she admitted to the facility on 4-9-19 with diagnoses of anxiety, hypertension and reflux disease. Review of the resident's functional capacity screen dated 4-9-19 revealed the resident required physical assistance with activities of daily living, could not manage his/her medications and medical treatments, had impaired cognition and bladder incontinence. Review of the negotiated service agreement dated 4-8-19 revealed staff assisted the resident with activities of daily living, administered his/her medications and provided incontinent care. It also revealed the resident received home health and hospice services. Review of the residents health care plan revealed the resident at risk for skin breakdown and staff needed to provide the following cares: toilet every 2 hours, reposition every 2 hours, check depends every 2 hours and as needed, make sure resident is clean after each bowel movement. Review of the Hospice notes in the Hospice notebook revealed the following skin condition concerns: 6-28-19 wounds to bilateral feet/ankles 7-8-19 skin tear from recent fall 7-22-19 skin tear to right side on bottom, sores to right knee	S5251		

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S5251	Continued From page 9 8-19-19 the resident had bilateral heel wounds. Review of the facilities decubitus/skin conditions form dated 8-30-19 revealed the resident had a stage 2 pressure ulcer to his/her coccyx and multiple skin tears. The coccyx wound measured 0.2cm x 0.2cm x 0.1 cm. During an observation on 9-18-19 at 2:15 PM with certified staff B revealed the resident had the following skin conditions: an open wound on his left outer knee; scabs on his right great toe and second toe; multiple red/bruised areas on bilateral knees and shins; large amount of bruising on his left arm; 3 small open pressure ulcers on his coccyx all were less than 0.3cm in diameter. The resident's record lacked evidence of the facility nurse identifying the resident had heel ulcers, wounds on the resident's ankle and only identified the 1 coccyx ulcer. It also lacked documentation of the current skin conditions the resident had. During an interview on 9-19-19 at 12:18 PM licensed nursing staff C reported he/she was not sure how indepth the documentation needed to be in the facility and Hospice was in charge of wound management. The operator failed to ensure designated staff included documentation of all incidents, symptoms for resident residents #918 and #928 related to falls and skin conditions in their resident records.	S5251		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications	S5300		

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S5300	Continued From page 10 (d) Home administration of resident ' s medications. If a home 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 home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 8 residents. The sample included 3 residents and 2 closed records. Based on interview and record review the Operator failed to ensure certified and licensed nursing staff administered medications according to standards of practice for 2 (#928 and #938) of 3 sampled residents regarding as needed (PRN) medications. Findings included: - Review of resident #928's medical record revealed the resident admitted to the facility on 4-9-19 with diagnoses of anxiety, constipation and hypertension.	S5300		

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S5300	Continued From page 11 Review of the functional capacity screen dated 4-9-19 revealed the resident was not able to manage his/her own medications and medical treatments. Review of the negotiated service agreement dated 4-8-19 revealed the facility staff administered the resident's medications. Review of the September 2019 medication administration record (MAR) revealed the resident received Morphine Sulfate (a narcotic pain medications) 0.5 ml. on the 2nd, 4th, 5th, 6th, 9th, 10th, 11th, and 12th of September. The MAR lacked documentation of time staff administered the medication, the reason the medication was given, and the effectiveness of the medication for all 8 times staff administer the Morphine. During an interview on 9-18-19 certified staff B reported he/she should have documented on the back of the MAR the time, why given, and if the medications was effective when giving the PRN Morphine. - Review of resident #938's medical record revealed the resident admitted into the facility on 5-3-19 with diagnoses of paranoid schizophrenia, dementia/alzheimers, and hypertension. Review of the residents functional capacity screen dated 5-3-19 revealed the resident could not manage his her medications or medical treatments. Review of the resident's functional capacity screen dated 5-3-19 revealed staff administered	S5300		

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S5300	Continued From page 12 the resident's medications. Review of the resident's September 2019 medication administration record revealed the resident received as needed (PRN) Tramadol 50 mg on the 9th and PRN Haloperidol (an antipsychotic) intramuscular injection on the 9th also. The MAR lacked documentation of the administration of the Tramadol and Haloperidol regarding time, reason, and effectiveness of medication. During an interview on 9-19-19 at 12:20 PM licensed nursing staff C reported PRN medications needed to include the time of administration, reason it was given and the effectiveness of the medication. The Operator failed to ensure staff administered PRN medication according to standards of practice.	S5300		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 (a)	S5335		

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S5335	Continued From page 13 The facility reported a census of 8 residents. Based on observation and interview the operator failed to ensure each exit door had only 1 locking device which released with operation of the inside door handle to maintain the safety of all residents, personnel, and the public. Findings included: - During initial tour on 9/18/19 at 9:17 AM observations of the exit doors revealed the following: The front entry door was locked, and observation revealed it had a turn locking device in the center of the door knob which did not release when the staff turned the door knob. The staff bathroom was not locked and had a turn knob to lock the door but it did not release when surveyor turned the knob. The patio door had a "lever" handle with a turn knob in middle to lock door that did not unlock when handle moved. The garage door had knob with turn lock in the door knob that did not unlock when handle moved. Interview with operator #A 9/18/19 at 10:05 AM reported he/she did not know that doors had to unlock with one turn. The Operator failed to ensure the exit doors had a locking device which released with the operation of the inside door handle.	S5335		