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	B087220	A. BUILDING: _____ B. WING _____	04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTRA CARE HOME PLUS	11537 E. HARRY STREET WICHITA, KS 67207

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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey conducted at the above named facility on 3/26/19, 4/1/19, 4/2/19, and 4/3/19.	S 000		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a) The facility reported a census of 8 residents. The sample included 3 residents. Based on observation, interview and record review, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services (HCS) to meet the needs for 1 of 3 sampled residents (#111) in accordance with the functional capacity screening (FCS) and negotiated service agreement (NSA) regarding the use of a bed assistive device.	S5105		

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

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S5105	Continued From page 1 Findings included: - The facility resident roster provided on 3/26/19 indicated no residents at the facility used an attached bed assistive device. - Record review for resident #111 revealed an admit date of 3/1/18 with diagnoses insulin dependent diabetic, hypertension, and osteoarthritis. The admission FCS dated 3/1/18 and annual FCS dated 2/27/19 recorded resident required supervision with walking/mobility, physical assistance with bathing, dressing, toileting, transfer, urinary incontinence, experienced short-term memory loss, memory recall, decision making, impaired vision, impaired hearing, and falls/unsteadiness. The admission NSA 3/1/18 and annual NSA dated 2/27/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, and experienced falls/unsteadiness. The admission HCS dated 3/1/18 and annual HCS dated 2/27/19 recorded staff to shower resident every other day and as needed, required complete assistance for dressing, physical assistance with changing depends and incontinent care. Ambulates with walker and standby assistance. The HCS lacked specifics about the resident's bed mobility, abilities to transfer from the bed or the use of a bed assistive device. The record lacked an assessment to verify the bed assistive device was not a restraint, the	S5105		

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resident used the bed assistive device safely and the bed assistive device design/attachment/gaps and mechanisms were safe.

The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows:
Zone 1 within the rail should measure less than 4 and 3/4 inches
Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and ¾ inches
Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches
Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches.

Observation on 3/26/19 at 12:10 p.m. revealed an upside down U-shaped assistive device on both sides of the resident's bed. The assistive device on side of bed not against the wall was in up position. When resident raised up he/she used the device to assist self in sitting up on side of bed.

Interview on 4/1/19 at 2:45 p.m. with operator/ registered nurse A confirmed the resident had the bed assistive device for positioning. He/she confirmed the record lacked an assessment of the resident's need for the assistive device or safety of the device.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary HCS to meet the needs for this resident in accordance with the FCS and NSA regarding the use of a bed assistive device.

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S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus 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: KAR 26-42-204(a) The facility identified a census of 8 residents. The sample included 3 residents. Based on record review, interview and observation for 3 (#111, #222, #333) of 3 residents sampled, the operator/Registered Nurse (RN) failed to ensure the provision of necessary Health Care Services (HCS) that meet the needs of each resident and are in accordance with the Functional Capacity Screen (FCS) and Negotiated Service Agreement (NSA). For resident #111, the HCS lacked interventions to reduce spread of infections. For resident #222, the HCS lacked appropriate interventions for cognitive impaired resident for falls. For resident #333, the HCS lacked interventions for confused resident who would get in other residents' beds. Findings included: - Record review for resident #111 revealed an admit date of 3/1/18 with diagnoses insulin	S5155		

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dependent diabetic, hypertension, and osteoarthritis.

The admission FCS dated 3/1/18 and annual FCS dated 2/27/19 recorded resident required supervision with walking/mobility, physical assistance with bathing, dressing, toileting, transfer, urinary incontinence, experienced short-term memory loss, memory recall, decision making, impaired vision, impaired hearing, and falls/unsteadiness.

The admission NSA 3/1/18 and annual NSA dated 2/27/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, and experienced falls/unsteadiness.

The admission HCS dated 3/1/18 and annual HCS dated 2/27/19 recorded staff to shower resident every other day and as needed, required complete assistance for dressing, physical assistance with changing depends and incontinent care. Ambulates with walker and standby assistance.

The HCS lacked interventions to reduce spread of infection as resident experienced 3 positive Clostridium Difficile (C-Diff) cultures (infections) since admission to facility. Resident symptomatic with each infection.

The nurses notes recorded the following:

3/2/18 at 9:45 p.m. Resident expressed frustration after incontinent episode earlier today. Resident had two loose bowel movements today. Encouraged resident to drink fluids and wash hands. Signed operator/RN A.

3/3/18 at 7:30 p.m. Resident had four episodes

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of mucous bowel movements with overly offensive odor. Stool culture obtained for C-Diff. Signed operator/RN A.

3/7/18 at 3:15 p.m. Resident continues to have loose mucoid stool. Stool culture positive for C-Diff. Medical care provider notified. Signed licensed nurse B.

3/7/18 at 3:30 p.m. Contact precaution instituted as soon as possible. Signed licensed nurse B.

3/7/18 at 3:45 p.m. New order for vancomycin 125 milligrams (MG) four times a day for fourteen days (for C-Diff infection.) Signed licensed nurse B.

3-10-18 at 10:30 p.m. Resident remains on contact precaution for C-Diff. No bowel movements today. Signed licensed nurse B.

4/4/18 at 1:45 p.m. Resident had form bowel movement. Colace 100 MG daily (for constipation). Signed licensed nurse B.

4/7/18 at 10:15 a.m. Resident has history of C-Diff and was treated recently for C-Diff. Resident had two loose mucoid stools today. New order to check stool for C-diff. Signe licensed nurse B.

4/7/18 at 7:45 p.m. New order for vancomycin 125 MG four times a day for twenty-one days. Stool culture positive for C-Diff. Signed operator/RN A.

4/9/18at 3:45 p.m. Contact precaution maintained. Signed licensed nurse B.

7/4/18 at 5:00 p.m. Resident had loose mucoid

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stools yesterday and one today. Resident has history of C-Diff. New order to obtain stool specimen to check for C-Diff. Stool culture sent to lab. Signed licensed nurse B.

7/4/18 at 9:30 p.m. Positive stool culture for C-Diff received. Contact precaution initiated. New order for fidaxomicin 200 MG daily for seven days (for C-Diff). Signed licensed nurse B.

7/5/18 at 1:30 p.m. Resident started on vancomycin 125 MG four times a day for twenty-one days. Fidaxomicin 200 MG copay was $3,000.00 and resident or family unable to meet needs. Signed operator/RN A.

7/11/18 at 7:30 p.m. Resident continued contact precautions for C-Diff. Signed licensed nurse B.

8/14/18 at 12:15 p.m. Resident completed antibiotic treatment and tolerated well. Signed operator/RN A.

Interview on 4/1/19 with operator/RN A stated and confirmed the HCS lacked interventions/instructions to staff for contact precautions and how to provide care for resident with symptomatic positive C-Diff.

For resident #111, the HCS lacked interventions to reduce spread of infections.

- Record review for resident #222 revealed an admission date of 5/1/18 with diagnoses of dementia, hypothyroidism, depression, anxiety, and heart disease.

The FCS dated 5/1/18 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, incontinent

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care, experienced poor memory recall, long term memory loss, decision making, impaired decision making, and falls/unsteadiness.

The NSA dated 4/26/18 recorded resident required physical assistance with bathing two times a week. Resident required physical assistance with dressing, toileting, transfer, walking/mobility. Mattress on floor beside bed, bed alarm as needed.

The NSA lacked interventions for poor memory recall, long term memory loss, decision making and impaired decision making.

The HCS dated 5/1/18 recorded hospice to provide bathing, staff to assist with dressing, occasionally incontinent and can state when needs to toilet. Staff to remind. Amendment dated 7/25/18 recorded fall and injury preventive measures: bed alarm will be attached to resident as needed. Mattress/foam will be on floor beside bed.
The HCS lacked interventions for cognition, memory recall, long term memory loss, decision making and impaired decision making.

The nurses notes recorded the following:

5/29/18 at 12:45 p.m. Resident agitated and confused. Wants to go to golf course and thinks room mate is stealing his/her treats. Signed operator/RN A.

6/13/18 at 6:15 p.m. Resident appears more confused and often saying things/events that did not happen. Signed operator/RN A.

6/27/18 at 6:45 a.m. Staff alerted this nurse that resident is on the mattress on floor. Resident

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sitting on mattress pad on floor upon my arrival. Resident stated trying to get shoes under bed. Call bell within reach but did not use it. Resident stated slid down on the floor. No complaints of discomfort. Signed licensed nurse B.

7/1/18 at 9:15 a.m. Resident very agitated and combative in middle of the night. Hallucinations has increased. Resident demanded staff to take him/her to where brothers and sisters were buried. Resident slid down out of chair because of agitation. Signed licensed nurse B.

7/4/18 at 5:00 p.m. Bed alarm instituted 3 days ago. Fall matt on floor beside bed. Call bell within reach. No recent attempt to climb out of bed. Signed licensed nurse B.

12/17/18 at 6:15 p.m. Resident was being combative when staff tried to put him/her to bed after supper. Refused to get in bed and insisted on sitting in chair beside closet. Staff left resident for a few minutes to calm down as resident was shouting and screaming, "leave me alone", came back in to find resident half out of chair and fell. Signed operator/RN A.

4/1/19 at 12:00 noon observed licensed nurse B transfer resident from wheel chair to bed without difficulty. Stated resident could stand but not walk. No call bell present, no bed alarm and fall matt under bed. Licensed nurse B left room.

4/1/19 at 1:00 p.m. observed resident in bed sleeping. Fall matt under bed, no call bell present.

4/1/19 at 1:40 p.m. Surveyor asked operator/RN A if resident to be in bed without call bell or button and fall matt under bed? Operator/RN A stated

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licensed nurse B put resident to bed. He/she forgot to pull fall matt out from under bed had him/her go get call button in facility living room. Operator/RN A stated bed alarm is as needed.

The HCS lacked interventions for use of call bell and bed alarm for cognitive impaired resident. The HCS also lacked instructions for "as needed" use of bed alarm and fall matt.

- Record review for resident #333 revealed an admit date of 9/4/18 with diagnoses of atrial fibrillation, hypertension, and macular degeneration.

The admission FCS dated 8/30/18 and significant change FCS dated 12/13/18 recorded resident required supervision with walking/mobility, required physical assistance with bathing dressing, toileting, transfer, incontinent of bladder control, experienced short-term memory, poor memory recall, long term memory loss, decision making, impaired decision making and falls/unsteadiness.

The admission NSA dated 8/30/18 and significant change NSA dated 12/31/18 recorded resident required physical assistance with bathing/sponge bath, dressing, toileting, transfers, grooming, has impaired decision making and is drowsy, sleeps 16 to 18 hours a day. Has history of falls.

The HCS dated 8/30/18 recorded staff to shower three times a week and give sponge bath on non-shower days, complete assist for dressing, occasionally incontinent of bladder control, provide incontinent care, staff to provide standby assist when resident ambulates with walker. Physical assist for transfers. Resident has confusion and forgetfulness, reorient frequently,

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awake resident at intervals to eat and participate in activities. Fall prevention: call light within reach and stand by assist with all ambulation.

The HCS dated 12/13/18 recorded staff to dress resident, provide incontinent care, encourage water, and toilet every hour. Staff to encourage resident to shout out for help as needed and standby assist with all ambulation.

The HCS lacked interventions for confusion and redirection when resident attempting to get in bed with room mate and other residents when in their rooms.

The record lacked documentation to indicate resident toileted hourly.

The nurse's notes recorded the following:

8/31/18 at 1:15 p.m. resident arrived at facility accompanied by family member. Resident fell at home yesterday. Resident is forgetful and repetitive. Signed operator/RN A.

9/13/18 at 3:45 p.m. Resident uses walker for ambulation. Ambulation is slow, gait is unsteady. Resident had fall at home prior to admission to facility. Signed licensed nurse B.

10/7/18 at 10:45 p.m. Resident was laying on side on mattress on the floor next to roommate. Resident stated was walking with walker and tripped on mattress. Staff to re-orient and check resident frequently on use of call light and make sure adequate lighting in room. Signed operator/RN A.

2/14/19 at 10:15 a.m. Resident more confused since yesterday. Mistook staff for family member.

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S5155	Continued From page 11 Certified staff D informed me that resident got up multiple times last night and was sometimes found sleeping beside roommate on roommate's bed and walking into another resident's room asking them to come and meet resident's spouse. Resident continued to be confused. Signed operator/RN A. On 4/1/19 at 2:15 p.m. observed resident sitting in recliner with feet elevated. Interview with operator/RN A stated resident is transferred to wheel chair and toileted and to bed. Resident likes to sleep a lot. Operator/RN A stated resident did get in bed with roommate and fell over roommate's fall matt. Confirmed no intervention in place and no documentation to identify resident toileted hourly. The HCS lacked appropriate interventions for increased confusion, fall from roommate's fall matt, getting into bed with other residents to sleep, and hourly toileting. For residents #111, #222, and #333, the operator/RN A failed to ensure the provision of necessary HCS that meet the needs of each resident and are in accordance with the FCS and NSA. For resident #111, the HCS lacked interventions to reduce spread of infections. For resident #222, the HCS lacked appropriate interventions for cognitive impaired resident for falls. For resident #333, the HCS lacked interventions for confused resident who would get in other residents' beds.	S5155		