STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints #140167 and #140170 at the above named facility on 5/6/19, 5/7/19, 5/8/19, 5/9/19, 5/13/19, 5/14/19, and 5/15/19.	S 000		
S5026 SS=G	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)(B) The facility identified a census of 7 residents. The sample included 3 residents. Based on record review, interview, observation for 1 (#100) of 3 residents sampled, the operator/Registered Nurse (RN) failed to ensure the resident was not subjected to neglect when a licensed nurse moved the resident following a fall with obvious injury to leg, failed to conduct an assessment of bed bound resident upon return from the hospital for surgery for fractures of tibia and fibula of right leg sustained during the fall, and failed to implement appropriate measures to prevent skin breakdown. Findings included:	S5026		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 1 - Record review for resident #100 revealed an admit date of 1/13/16 with diagnoses of insulin dependent diabetic, osteoarthritis, osteoporosis, 3/18/19 new diagnosis fractures of right tibia and fibula. The annual Functional Capacity Screen (FCS) dated 5/1/18 recorded resident independent with eating, continent of bowel/bladder control, required physical assistance with bathing, dressing, unable to assist with toileting, transfer, walking/mobility, experienced decision making, impaired vision, impaired decision making, socially inappropriate disruptive behaviors, and falls/unsteadiness. The significant change FCS dated 4/3/19 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, eating, has Foley catheter, experienced poor decision-making, impaired decision making, impaired vision, socially inappropriate disruptive behaviors, and falls/unsteadiness. The annual Negotiated Service Agreement (NSA) dated 5/1/18 recorded resident required insulin to be administered by nurses, and simple wound care, edema, and skin assessment to be supervised by nursing services. Need/Preferences: monitoring of insulin orders, blood sugar and insulin. Monitor skin during showers and as needed during daily cares. Call staff for assist to toilet. Mechanical sit to stand lift with two staff, two staff pivots at times. Can propel self in wheelchair. The significant change NSA dated 4/1/19 Skilled nursing services to be provided: injections wound care. Supervised nursing services to be	S5026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 2	S5026		

provided: monitoring of insulin, skin assessment, simple wound care. Need/Preferences: Insulin orders, blood sugars, wound care to heels and right buttocks, fracture of right fibula and tibia with surgical repair. Two bed baths per week due to fractures. Wearing hospital gowns at present time. Needs/preferences total care with bathing, Foley catheter care and empty bag each shift, turn from side to side as resident is bed bound at present time due to fractures of right tibia/fibula.

The annual Health Care Plan (HCP) dated 5/1/18 recorded assist one for dressing, shower, toileting, uses mechanical sit to stand lift with two staff for transfer. Resident's skin is assessed during showers on Tuesdays, Fridays, and as needed with dressing and undressing. Any skin issues are reported so order can be obtained as needed. Resident can feed self and is insulin dependent diabetic. Keep personal sit to stand lift in room. Resident is alert and oriented. No skin issues at this time. Staff continues to monitor skin. 7/2/18 cellulitis to legs, apply compression wraps till no longer needed.

The significant change HCP dated 4/3/19 (resident returned on 4/1/19) recorded resident wearing hospital gown at present due to fractured tibia/fibula and being bed bound. Bed baths to be given on Monday and Thursdays, Foley catheter emptied every shift. Transfer: Resident is bed bound at present time - turn slightly from side to side to prevent pressure ulcers. Skin needs: Assessed on Mondays and Thursdays and during showers. Resident total assist for feeding. Resident can be very demanding, rude, unreasonable, and unrealistic to staff. Can become very volatile and angry. Resident has wounds to left and right heels and right buttocks. (Written under last sentence left heel wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 3	S5026		

occurred during hospital stay) Signed by licensed nurse C.

The significant change HCP dated 4/3/19 lacked interventions/services to be provided for skin break down, care and services for fractured right tibia/fibula with leg immobilizer and lacked information to identify resident required a Hoyer lift for transfers as resident is non-weight bearing. The record lacked documentation of description of wounds to left and right heels, right buttock and services to be provided for care of wounds.

Hospital history and physical upon admission on 3/18/19 recorded Impression:

1. Bilateral pulmonary edema with bilateral pleural effusion. 2. Bilateral lower extremity edema. 3. Acute tibial fibular fracture secondary to fall. 4. Status post right tibial nailing postop day #4. 5. Acute hypoxic respiratory failure improving. 6. Bibasilar segmental lung atelectasis. Orders per hospitalist indicate to transfer only with a lift. Resident is now non-weight bearing due to the right lower extremity fracture/repair. Do not feel she will be appropriate to advance mobility outside of lift use at the at this time.

History and physical from hospital dated 3/22/19 recorded:

Patient alert, reports she fell out of a chair after an insulin reaction, breaking her right leg. Patient did have a tibia/fibula fracture that required surgical intervention with rod placement. Patient reports she had not walked in years due to multiple reasons and lives in a facility. There are not obvious open wounds. She has some chronic appearing erythema with peeling skin over the left lower extremity which appears more subacute to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 4	S5026		

chronic to me. I would recommend continuing with the ancef (antibiotic) for cellulitis involving the left foot. Signed by physician.

The nurses notes recorded the following:

1/28/19 9:00 a.m. While routine nail care being done noted an ulcer to left foot 4th digit. Dressed with triple antibiotic ointment and band aide and physician will be notified. Signed licensed nurse/operator B.

1/29/19 12:00 noon, Mobil x-ray here to do arterial doppler. Results 1/29/19 Impression: Marked acceleration in the left popliteal artery suggesting non-visualized stenosis. There is not vessel occlusion. Reported to physician. 1/30/19 report faxed to physician who wants to refer resident to vascular surgeon. Signed licensed nurse/operator B.

No further documentation about feet/toe skin break down until:

3/4/19 1:00 p.m. Physician in for rounds and ordered Bactrim DS one orally two times a day for 14 days for cellulitis. Signed licensed nurse/operator B. (Notes do not identify where cellulitis is.)

3/5/19 8:00 p.m. Staff notified me of rash on back of resident's neck. Bactrim discontinued and Keflex 250 MG four times a day for 10 days for cellulitis of lower extremities. Signed operator/RN.

No further documentation until 3/18/19

3/18/19 7:15 a.m. Staff called me at home and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 5	S5026		

reported resident had recliner chair in highest position and was on the floor. BS 58 and instructed staff to give one half can of pop kept under bed. When I arrived, resident was alert and oriented. Back was next to recliner with right lower leg bent under right thigh. The knee appeared to rotate inward. We repositioned her so she was flat on back. Resident complained of right leg pain. Physician called to see if wanted portable x-ray but since it appeared knee was turned wanted resident to go to hospital. EMS called and resident transferred to hospital at 9:00 a.m. Resident was transferred to another hospital for surgery the following day for right tibia/fibula fracture. Signed operator/RN.

3/20/19 (no time) Report from family stated the doctor informed them residents boned are like butter and he didn't have to drill to put screws in top of leg when they put a rod to stabilize the bones and unable to close bottom. Leg is to be kept straight. Signed operator/RN.

3/24/19 (no time) Report from family today, plan to send resident home tomorrow. Resident is being fed in the hospital and to be on bed rest for three weeks. Signed operator/RN.

3/25/19 3:40 p.m. Arrived at facility by (transfer agency) on gurney. It took 4 people and the use of a sheet to transfer resident from gurney to bed and an extra person to support right leg for transfer. Head of bed elevated due to complaint of shortness of breath. Family present and stated was told bones are like butter. Oxygen on via nasal cannula at 2 liters/minute. Resident now speaks very softly almost non-audible. Alert and oriented to person, place, and name. Two plus edema noted to right lower leg on foot. Brace in place on right leg. Diagnosis fracture repair of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 6	S5026		

right tibia/fibula fracture. Foley catheter in place and to stay in until resident has more mobility. Signed licensed nurse/operator B.

3/26/19 4:06 p.m. turned and repositioned just enough to get pressure of bottom while keeping right leg straight. At 4:10 p.m. right leg ace wrap in place below brace. B/P 148/74, P 80, R 16, T 98.8, oxygen on at 3 liter/minute via nasal cannula. Continue two plus edema right foot. Resident repositioned every two hours. Head of bed elevated with pillows behind head/neck. Signed licensed nurse/operator B.

No further documentation in notes until 3/30/19

3/30/19 7:00 a.m. to 8:00 p.m. Resident continues to be in bed with brace and wrap to right leg in place. Resident turned slightly to help with pressure relief for buttocks with right leg straight. Staff continues to feed resident. Resident wanting to get up out of bed and into recliner. Staff continued to remind her that she needs to let leg heal first. Signed licensed nurse F.

3/31/19 7:00 a.m. to 8:00 p.m. Resident continued on bed rest. Leg continued with brace and wrap to right leg. Turned and repositioned slightly to relieve pressure off buttock. Have maintained keeping leg straight throughout this shift. Signed licensed nurse F.

No documentation until 4/2/19.

4/2/19 2:15 p.m. Nurse for physician stated if could arrange for resident to come to appointment on gurney would bed best way for appointment. Signed licensed nurse/operator B.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 7	S5026		

4/3/19 at 10:15 p.m. Left and right heel blackened like blood blister appearance. Complained of pain on right heel, both heels off loaded. 3 Centimeter (CM) in diameter on both heels. Open area noted to left buttock 3 1/2 CM in diameter. Call placed to medical care provider to report. Orders to apply barrier prep to left heel after cleaned with wound cleanser cover with meplix dressing. Change daily and as needed. Cleanse left buttock with would cleanser and apply meplix every day and as needed. Barrier prep to right heel every day after cleansed with wound cleanser. Signed licensed nurse/operator B.

4/3/19 at 10:30 a.m. Family notified of new orders for skin break down on both heels and buttocks. Family stated, "yea, I was worried about that as she had a spot on left heel at the hospital. Off-loading feet every two hours while leg remain straight/immobile. Removed ace wrap after opening brace. Signed licensed nurse/operator B.

No further documentation until 4/7/19.

4/7/19 2:00 a.m. Staff called this nurse due to complaint of back pain. Norco 5/325 MG given and repositioned. Dressings to heels and buttocks intact, off loaded heels and put pillow under buttocks. Signed operator/RN.

4/7/19 3:00 a.m. Stayed to be sure pain medication effective and made comfortable. Oxygen saturation decreased to 72 %. Has shallow breathing and lung sounds diminished throughout. Put on mask as oxygen saturations continue to be in 80's. Put oxygen up to 5 liters/minutes. Called family to notify of resident condition and asked if wanted to send resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 8	S5026		

hospital. Family was hesitant due to resident's condition from previous post-surgery. Physician requested resident be sent to hospital via non-emergency transfer. at 7:30 a.m. resident transferred. Signed operator/RN.

4/11/19 2:45 p.m. Resident returned to facility by ambulance with diagnoses pneumonia. Stitches (staples) removed from right knee incision at the hospital. Brace on and heels medicated and wrapped. Heels off loaded from bed. Blister tip of right toe. Stated is glad to be back home. Signed operator/RN.

4/13/19 8:00 a.m. to 8:00 p.m. Resident resting and turned every two hours with heels off loaded. Signed licensed nurse F.

4/15/19 8:00 p.m. "Girls assisting resident getting ready for bed. Discussed she could have brace off for the night. She chose to leave it on." Signed operator/RN.

4/16/19 (no time) Received a call at 2:45 a.m. that resident couldn't get comfortable and complained of left leg pain. This nurse came to facility and administered hydrocodone/acetaminophen 5/325 MG for pain. Resident requested to have brace removed. Repositioned again. At 3:30 a.m. resting. Signed operator/RN.

4/16/19 (no time) Received orders from hospice. Right leg brace to be removed greater than 12 hours 24 hours a day. Removed brace from bed to allow adequate movement and circulation to skin. Change linen as necessary from perspiration to avoid additional skin break down. Signed licensed nurse C.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 9 No further documentation about skin break down in nurses notes. Written statement from licensed nurse C on 5/9/19 at 10:00 p.m. stated did not assess resident for skin break down upon return from hospital but did assess skin on 4/3/19. Interview on 5/6 19 at 1:00 p.m. with certified staff D stated tried to reposition resident #100 from side to side without moving right leg when first came home from hospital. Unable to put on side due to keeping right leg straight. 5/6/19 at 2:55 p.m. observed certified staff D and E transfer resident #100 from bed to recliner. Staff pulled covers back to place mobilizer under resident's right leg. Noted a staple in healed incision on right leg knee area. Staff certified staff stated had not seen it before. Left heel stuck to pad under it and pulled off during transfer. Noted black dried area with blister on right and left heels. Approximately 3 CM in diameter. Observed blood coming from two blisters on left forearm. Certified staff D and E confirmed left arm bleeding from dark blister on arm. Sling placed under resident while staff carefully transferred resident from bed to recliner. Feet elevated up off foot rest with pillows. Resident made comfortable. Interview on 5/6/19 at 3:45 p.m. with licensed nurse/operator B stated certified staff D and E off work at 3:30 p.m. Asked licensed nurse/operator B if staff notified her of resident #100's left arm bleeding prior to leaving facility. Licensed nurse/operator B was not aware of left arm bleeding. Went to resident #100's room and observed blood on gown and chair coming from left arm. Licensed nurse/operator B then	S5026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5026	Continued From page 10 cleansed area with wound cleanser and dressing applied. Interview on 5/6/19 at 4:20 p.m. with licensed nurse/operator B stated hospice providing wound care and did not document what wound looked like. Home health nurse G stated checked resident #100's skin and stated no skin break down upon return from hospital. Since home health nurse stated no skin break down he/she did not assess skin after return from hospital. Licensed nurse/operator B also stated was not aware resident had a staple in healed incision on right leg. For resident #100, the operator/RN failed to ensure the resident was not subjected to neglect when a licensed nurse moved the resident following a fall with obvious injury to leg, failed to conduct an assessment of bed bound resident upon return from the hospital for surgery for fractures of tibia and fibula of right leg sustained during the fall, and failed to implement appropriate measures to prevent skin breakdown.	S5026		
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.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility identified a census of 7 residents. The sample included 3 residents. Based on observation, interview, and record review for 1 (#100) of 3 residents sampled, the operator/Registered Nurse (RN) failed to ensure a licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) to meet the needs for resident #100 for decubitus ulcers when developed, the use of a bed assistive device, and use of Hoyer lift for transfer. These needs are not in accordance with the Functional Capacity Screen (FCS) and the Negotiated Service Agreement (NSA). Findings included: - Record review for resident #100 revealed an admit date of 1/13/16 with diagnoses of insulin dependent diabetic, osteoarthritis, osteoporosis, 3/18/19 new diagnosis fractures of right tibia and fibula. The annual Functional Capacity Screen (FCS) dated 5/1/18 recorded resident independent with eating, continent of bowel/bladder control, required physical assistance with bathing, dressing, unable to assist with toileting, transfer, walking/mobility, experienced decision making, impaired vision, impaired decision making, socially inappropriate disruptive behaviors, and falls/unsteadiness. The significant change FCS dated 4/3/19 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, eating, has Foley catheter, experienced poor	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 12	S5155		

decision-making, impaired decision making, impaired vision, socially inappropriate disruptive behaviors, and falls/unsteadiness.

The annual Negotiated Service Agreement (NSA) dated 5/1/18 recorded resident required insulin to be administered by nurses, and simple wound care, edema, and skin assessment to be supervised by nursing services. Need/Preferences: monitoring of insulin orders, blood sugar and insulin. Monitor skin during showers and as needed during daily cares. Call staff for assist to toilet. Mechanical sit to stand lift with two staff, two staff pivots at times. Can propel self in wheelchair.

The significant change NSA dated 4/1/19 Skilled nursing services to be provided: injections wound care. Supervised nursing services to be provided: monitoring of insulin, skin assessment, simple wound care. Need/Preferences: Insulin orders, blood sugars, wound care to heels and right buttocks, fracture of right fibula and tibia with surgical repair. Two bed baths per week due to fractures. Wearing hospital gowns at present time. Needs/preferences total care with bathing, Foley catheter care and empty bag each shift, turn from side to side as resident is bed bound at present time due to fractures of right tibia/fibula.

The annual Health Care Plan (HCP) dated 5/1/18 recorded assist one for dressing, shower, toileting, uses mechanical sit to stand lift with two staff for transfer. Resident's skin is assessed during showers on Tuesdays, Fridays, and as needed with dressing and undressing. Any skin issues are reported so order can be obtained as needed. Resident can feed self and is insulin dependent diabetic. Keep personal sit to stand lift in room. Resident is alert and oriented. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 13 skin issues at this time. Staff continues to monitor skin. 7/2/18 cellulitis to legs, apply compression wraps till no longer needed. The significant change HCP dated 4/3/19 (resident returned on 4/1/19) recorded resident wearing hospital gown at present due to fractured tibia/fibula and being bed bound. Bed baths to be given on Monday and Thursdays, Foley catheter emptied every shift. Transfer: Resident is bed bound at present time - turn slightly from side to side to prevent pressure ulcers. Skin needs: Assessed on Mondays and Thursdays and during showers. Resident total assist for feeding. Resident can be very demanding, rude, unreasonable, and unrealistic to staff. Can become very volatile and angry. Resident has wounds to left and right heels and right buttocks. (Written under last sentence left heel wound occurred during hospital stay) Signed by licensed nurse C. The significant change HCP dated 4/3/19 lacked interventions/services to be provided for skin break down, care and services for fractured right tibia/fibula with leg immobilizer and lacked information to identify resident required a Hoyer lift for transfers as resident is non-weight bearing. The record lacked documentation of description of wounds to left and right heels, right buttock and services to be provided for care of wounds. Order from medical care provider dated 4/24/19 recorded (resident) may be up in recliner, wheelchair, or shower chair, transfer with mechanical lift. Clean wounds with wound cleanser spray, apply foam dressing to cover and on buttocks wound. Wound care two times weekly and as needed.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 14 The nurses notes recorded the following: 1/28/19 9:00 a.m. While routine nail care being done noted an ulcer to left foot 4th digit. Dressed with triple antibiotic ointment and band aide and physician will be notified. Signed licensed nurse/operator B. 1/29/19 12:00 noon, Mobil x-ray here to do arterial doppler. Results 1/29/19 Impression: Marked acceleration in the left popliteal artery suggesting non-visualized stenosis. There is not vessel occlusion. Reported to physician. 1/30/19 report faxed to physician who wants to refer resident to vascular surgeon. Signed licensed nurse/operator B. No further documentation about feet/toe skin break down until: 3/4/19 1:00 p.m. Physician in for rounds and ordered Bactrim DS one orally two times a day for 14 days for cellulitis. Signed licensed nurse/operator B. (Notes do not identify where cellulitis is.) 3/5/19 8:00 p.m. Staff notified me of rash on back of resident's neck. Bactrim discontinued and Keflex 250 MG four times a day for 10 days for cellulitis of lower extremities. Signed operator/RN. No further documentation until 3/18/19 3/18/19 7:15 a.m. Staff called me at home and reported resident had recliner chair in highest position and was on the floor. BS 58 and instructed staff to give one half can of pop kept under bed. When I arrived, resident was alert	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 15 and oriented. Back was next to recliner with right lower leg bent under right thigh. The knee appeared to rotate inward. We repositioned her so she was flat on back. Resident complained of right leg pain. Physician called to see if wanted portable x-ray but since it appeared knee was turned wanted resident to go to hospital. EMS called and resident transferred to hospital at 9:00 a.m. Resident was transferred to another hospital for surgery the following day for right tibia/fibula fracture. Signed operator/RN. 3/20/19 (no time) Report from family stated the doctor informed them residents boned are like butter and he didn't have to drill to put screws in top of leg when they put a rod to stabilize the bones and unable to close bottom. Leg is to be kept straight. Signed operator/RN. 3/24/19 (no time) Report from family today, plan to send resident home tomorrow. Resident is being fed in the hospital and to be on bed rest for three weeks. Signed operator/RN. 3/25/19 3:40 p.m. Arrived at facility by (transfer agency) on gurney. It took 4 people and the use of a sheet to transfer resident from gurney to bed and an extra person to support right leg for transfer. Head of bed elevated due to complaint of shortness of breath. Family present and stated was told bones are like butter. Oxygen on via nasal cannula at 2 liters/minute. Resident now speaks very softly almost non-audible. Alert and oriented to person, place, and name. Two plus edema noted to right lower leg on foot. Brace in place on right leg. Diagnosis fracture repair of right tibia/fibula fracture. Foley catheter in place and to stay in until resident has more mobility. Signed licensed nurse/operator B.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 16 3/26/19 4:06 p.m. turned and repositioned just enough to get pressure of bottom while keeping right leg straight. At 4:10 p.m. right leg ace wrap in place below brace. B/P 148/74, P 80, R 16, T 98.8, oxygen on at 3 liter/minute via nasal cannula. Continue two plus edema right foot. Resident repositioned every two hours. Head of bed elevated with pillows behind head/neck. Signed licensed nurse/operator B. No further documentation in notes until 3/30/19 3/30/19 7:00 a.m. to 8:00 p.m. Resident continues to be in bed with brace and wrap to right leg in place. Resident turned slightly to help with pressure relief for buttocks with right leg straight. Staff continues to feed resident. Resident wanting to get up out of bed and into recliner. Staff continued to remind her that she needs to let leg heal first. Signed licensed nurse F. 3/31/19 7:00 a.m. to 8:00 p.m. Resident continued on bed rest. Leg continued with brace and wrap to right leg. Turned and repositioned slightly to relieve pressure off buttock. Have maintained keeping leg straight throughout this shift. Signed licensed nurse F. No documentation until 4/2/19. 4/2/19 2:15 p.m. Nurse for physician stated if could arrange for resident to come to appointment on gurney would bed best way for appointment. Signed licensed nurse/operator B. 4/3/19 at 10:15 p.m. Left and right heel blackened like blood blister appearance. Complained of pain on right heel, both heels off loaded. 3 Centimeter (CM) in diameter on both heels.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 17 Open area noted to left buttock 3 1/2 CM in diameter. Call placed to medical care provider to report. Orders to apply barrier prep to left heel after cleaned with wound cleanser cover with meplix dressing. Change daily and as needed. Cleanse left buttock with would cleanser and apply meplix every day and as needed. Barrier prep to right heel every day after cleansed with wound cleanser. Signed licensed nurse/operator B. 4/3/19 at 10:30 a.m. Family notified of new orders for skin break down on both heels and buttocks. Family stated, "yea, I was worried about that as she had a spot on left heel at the hospital. Off-loading feet every two hours while leg remain straight/immobile. Removed ace wrap after opening brace. Signed licensed nurse/operator B. No further documentation until 4/7/19. 4/7/19 2:00 a.m. Staff called this nurse due to complaint of back pain. Norco 5/325 MG given and repositioned. Dressings to heels and buttocks intact, off loaded heels and put pillow under buttocks. Signed operator/RN. 4/7/19 3:00 a.m. Stayed to be sure pain medication effective and made comfortable. Oxygen saturation decreased to 72 %. Has shallow breathing and lung sounds diminished throughout. Put on mask as oxygen saturations continue to be in 80's. Put oxygen up to 5 liters/minutes. Called family to notify of resident condition and asked if wanted to send resident to hospital. Family was hesitant due to resident's condition from previous post-surgery. Physician requested resident be sent to hospital via non-emergency transfer. at 7:30 a.m. resident	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 18	S5155		

transferred. Signed operator/RN.

4/11/19 2:45 p.m. Resident returned to facility by ambulance with diagnoses pneumonia. Stitches (staples) removed from right knee incision at the hospital. Brace on and heels medicated and wrapped. Heels off loaded from bed. Blister tip of right toe. Stated is glad to be back home. Signed operator/RN.

4/13/19 8:00 a.m. to 8:00 p.m. Resident resting and turned every two hours with heels off loaded. Signed licensed nurse F.

4/15/19 8:00 p.m. "Girls assisting resident getting ready for bed. Discussed she could have brace off for the night. She chose to leave it on." Signed operator/RN.

4/16/19 (no time) Received a call at 2:45 a.m. that resident couldn't get comfortable and complained of left leg pain. This nurse came to facility and administered hydrocodone/acetaminophen 5/325 MG for pain. Resident requested to have brace removed. Repositioned again. At 3:30 a.m. resting. Signed operator/RN.

4/16/19 (no time) Received orders from hospice. Right leg brace to be removed greater than 12 hours 24 hours a day. Removed brace from bed to allow adequate movement and circulation to skin. Change linen as necessary from perspiration to avoid additional skin break down. Signed licensed nurse C.

No further documentation about skin break down in nurses notes.

Written statement from licensed nurse C on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 19 5/9/19 at 10:00 p.m. stated did not assess resident for skin break down upon return from hospital but did assess skin on 4/3/19. Interview on 5/6 19 at 1:00 p.m. with certified staff D stated tried to reposition resident #100 from side to side without moving right leg when first came home from hospital. Unable to put on side due to keeping right leg straight. 5/6/19 at 2:55 p.m. observed certified staff D and E transfer resident #100 from bed to recliner. Staff pulled covers back to place mobilizer under resident's right leg. Observed 1/2 side rails up on side of both sides of bed. Noted a staple in healed incision on right leg knee area. Staff certified staff stated had not seen it before. Left heel stuck to pad under it and pulled off during transfer. Noted black dried area with blister on right and left heels. Approximately 3 CM in diameter. Observed blood coming from two blisters on left forearm. Certified staff D and E confirmed left arm bleeding from dark blister on arm. Sling placed under resident while staff carefully transferred resident from bed to recliner. Feet elevated up off foot rest with pillows. Resident made comfortable. Interview on 5/6/19 at 4:20 p.m. with licensed nurse/operator B stated hospice providing wound care and did not document what wound looked like. Home health nurse G stated checked resident #100's skin and stated no skin break down upon return from hospital. Since home health nurse stated no skin break down he/she did not assess skin after return from hospital. Licensed nurse/operator B also stated was not aware resident had a staple in healed incision on right leg or that an assessment of side rail bed	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5155	Continued From page 20 assistive device required. The record lacked an assessment to verify the bed assistive device was not a restraint, the 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 3/4 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. The NSA/HCS lacked documentation for instructions of how to use Hoyer lift, wound care interventions, and use of bed assistive device. For resident #100, the operator/RN failed to ensure a licensed nurse provided or coordinated the provision of necessary HCS to meet the needs for resident #100 for decubitus ulcers when developed, the use of a bed assistive device, and use of Hoyer lift for transfer. These needs are not in accordance with the FCS and the NSA.	S5155		
S5192 SS=F	26-42-206 (e) Food Preparation	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 21 (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility identified a census of 6 residents. The sample included 3 residents. Based on observations, interview, and record review for all residents, the operator/licensed nurse failed to ensure all food prepared using safe methods that conserved the nutritive value, flavor, and appearance and was served at the proper temperature. Findings included: - On 5/6/19 at 12:30 p.m. observed lunch crock pot coffee pot roast, carrots, and mashed potatoes with certified staff E. Requested to review temperature log for meal temperatures after finished with meal.	S5192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5192	Continued From page 22 On 5/7/17 at 12:15 p.m. food temperature log book provided from certified staff D. The temperature log book lacked food temperatures for 25 days out of 30 days in April 2019. For March 2019 lacked food temperatures for 13 days out of 31 days. February 2019 lacked food temperatures for 16 days out of 28 days. January 2019 lacked food temperatures for 5 days out of 30 recorded. Interview on 5/7/19 with licensed nurse/operator B stated and confirmed food temperatures was not checked daily for proper temperature. For all residents the operator/licensed nurse failed to ensure all food prepared using safe methods that conserved the nutritive value, flavor, and appearance and was served at the proper temperature.	S5192		
S5215 SS=F	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (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.	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5215	Continued From page 23 This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d) The facility identified a census of 7 residents. The sample included 3 residents. For all residents, the operator/Registered Nurse (RN) failed to ensure a quarterly review of the home's emergency management plan reviewed with employees and residents. Findings included: - Review of disaster and emergency management plan on 5/6/19 at 2:25 p.m. lacked quarterly review of the plan with employees and residents. Interview on 5/6/19 at 2:30 p.m. with licensed nurse/operator B stated had not reviewed plan with employees or residents quarterly. For all residents, the operator/RN failed to ensure a quarterly review of the home's emergency management plan reviewed with employees and residents.	S5215		
S5230 SS=E	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 24 annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-207(c) The facility identified a census of 7 residents. The sample included 3 residents and 5 employees. For 3 of 5 employee records reviewed, the operator/Registered Nurse (RN) failed to ensure the home's compliance with the department's Tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Personnel records reviewed on 5/7/19 at 12:15 p.m. with operator/licensed nurse B revealed the following: Licensed nurse B hired on 3/14/19 lacked a two-step TB skin test. Certified staff H hired on 3/20/19 lacked a two-step TB skin test. Certified staff I hired on 3/8/19 lacked a two-step TB skin test. Interview on 5/7/19 at 12:20 p.m. with operator/licensed nurse B stated and confirmed a two-step TB skin test was not performed on licensed nurse B, certified staff H and I upon hire.	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5230	Continued From page 25 For 3 of 5 employee records reviewed, the operator/RN failed to ensure the home's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		
S5251 SS=D	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f) (11) The facility identified a census of 7 residents. The sample included 3 residents. Based on record review, interview, and observation for resident 1 (#100) of 3 residents sampled, the operator/Registered Nurse (RN) failed to ensure the resident record included documentation of all incidents including the date, time, actions taken, and results of actions taken. Findings included: - Record review for resident #100 revealed an admit date of 1/13/16 with diagnoses of insulin dependent diabetic, osteoarthritis, osteoporosis, 3/18/19 new diagnosis fractures of right tibia and fibula. The annual Functional Capacity Screen (FCS) dated 5/1/18 recorded resident independent with	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 26	S5251		

eating, continent of bowel/bladder control, required physical assistance with bathing, dressing, unable to assist with toileting, transfer, walking/mobility, experienced decision making, impaired vision, impaired decision making, socially inappropriate disruptive behaviors, and falls/unsteadiness.

The significant change FCS dated 4/3/19 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, eating, has Foley catheter, experienced poor decision-making, impaired decision making, impaired vision, socially inappropriate disruptive behaviors, and falls/unsteadiness.

The annual Negotiated Service Agreement (NSA) dated 5/1/18 recorded resident required insulin to be administered by nurses, and simple wound care, edema, and skin assessment to be supervised by nursing services. Need/Preferences: monitoring of insulin orders, blood sugar and insulin. Monitor skin during showers and as needed during daily cares. Call staff for assist to toilet. Mechanical sit to stand lift with two staff, two staff pivots at times. Can propel self in wheelchair.

The significant change NSA dated 4/1/19 Skilled nursing services to be provided: injections wound care. Supervised nursing services to be provided: monitoring of insulin, skin assessment, simple wound care. Need/Preferences: Insulin orders, blood sugars, wound care to heels and right buttocks, fracture of right fibula and tibia with surgical repair. Two bed baths per week due to fractures. Wearing hospital gowns at present time. Needs/preferences total care with bathing, Foley catheter care and empty bag each shift, turn from side to side as resident is bed bound at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 27 present time due to fractures of right tibia/fibula. The annual Health Care Plan (HCP) dated 5/1/18 recorded assist one for dressing, shower, toileting, uses mechanical sit to stand lift with two staff for transfer. Resident's skin is assessed during showers on Tuesdays, Fridays, and as needed with dressing and undressing. Any skin issues are reported so order can be obtained as needed. Resident can feed self and is insulin dependent diabetic. Keep personal sit to stand lift in room. Resident is alert and oriented. No skin issues at this time. Staff continues to monitor skin. 7/2/18 cellulitis to legs, apply compression wraps till no longer needed. The significant change HCP dated 4/3/19 (resident returned on 4/1/19) recorded resident wearing hospital gown at present due to fractured tibia/fibula and being bed bound. Bed baths to be given on Monday and Thursdays, Foley catheter emptied every shift. Transfer: Resident is bed bound at present time - turn slightly from side to side to prevent pressure ulcers. Skin needs: Assessed on Mondays and Thursdays and during showers. Resident total assist for feeding. Resident can be very demanding, rude, unreasonable, and unrealistic to staff. Can become very volatile and angry. Resident has wounds to left and right heels and right buttocks. (Written under last sentence left heel wound occurred during hospital stay) Signed by licensed nurse C. The significant change HCP dated 4/3/19 lacked interventions/services to be provided for skin break down, care and services for fractured right tibia/fibula with leg immobilizer and lacked information to identify resident required a Hoyer lift for transfers as resident is non-weight bearing.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 28 The record lacked documentation of description of wounds to left and right heels, right buttock and services to be provided for care of wounds. Order from medical care provider dated 4/24/19 recorded (resident) may be up in recliner, wheelchair, or shower chair, transfer with mechanical lift. Clean wounds with wound cleanser spray, apply foam dressing to cover and on buttocks wound. Wound care two times weekly and as needed. The nurses notes recorded the following: 1/28/19 9:00 a.m. While routine nail care being done noted an ulcer to left foot 4th digit. Dressed with triple antibiotic ointment and band aide and physician will be notified. Signed licensed nurse/operator B. The record lacked documentation of signs/symptoms, injury, date, time of occurrence, actions taken and results of actions taken. 3/4/19 1:00 p.m. Physician in for rounds and ordered Bactrim DS one orally two times a day for 14 days for cellulitis. Signed licensed nurse/operator B. The notes do not identify where cellulitis is, signs/symptoms, other indications of illness, injury, date, time, actions taken and results of actions taken. 3/5/19 8:00 p.m. Staff notified me of rash on back of resident's neck. Bactrim discontinued and Keflex 250 MG four times a day for 10 days for cellulitis of lower extremities. Signed	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 29 operator/RN. The record lacked date/time of actions taken and results of actions taken. 3/18/19 7:15 a.m. Staff called me at home and reported resident had recliner chair in highest position and was on the floor. BS 58 and instructed staff to give one half can of pop kept under bed. When I arrived, resident was alert and oriented. Back was next to recliner with right lower leg bent under right thigh. The knee appeared to rotate inward. We repositioned her so she was flat on back. Resident complained of right leg pain. Physician called to see if wanted portable x-ray but since it appeared knee was turned wanted resident to go to hospital. EMS called and resident transferred to hospital at 9:00 a.m. Resident was transferred to another hospital for surgery the following day for right tibia/fibula fracture. Signed operator/RN. 3/20/19 (no time) Report from family stated the doctor informed them residents boned are like butter and he didn't have to drill to put screws in top of leg when they put a rod to stabilize the bones and unable to close bottom. Leg is to be kept straight. Signed operator/RN. The record lacked the time family reported to nurse, actions taken and results of actions taken. 3/24/19 (no time) Report from family today, plan to send resident home tomorrow. Resident is being fed in the hospital and to be on bed rest for three weeks. Signed operator/RN. The record lacked the time family gave report on resident.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 30 3/25/19 3:40 p.m. Arrived at facility by (transfer agency) on gurney. It took 4 people and the use of a sheet to transfer resident from gurney to bed and an extra person to support right leg for transfer. Head of bed elevated due to complaint of shortness of breath. Family present and stated was told bones are like butter. Oxygen on via nasal cannula at 2 liters/minute. Resident now speaks very softly almost non-audible. Alert and oriented to person, place, and name. Two plus edemas noted to right lower leg on foot. Brace in place on right leg. Diagnosis fracture repair of right tibia/fibula fracture. Foley catheter in place and to stay in until resident has more mobility. Signed licensed nurse/operator B. The record lacked signs/symptoms, other indications of illness or injury including the date, time of occurrence, actions taken and results of actions taken. 3/26/19 4:06 p.m. turned and repositioned just enough to get pressure of bottom while keeping right leg straight. At 4:10 p.m. right leg ace wrap in place below brace. B/P 148/74, P 80, R 16, T 98.8, oxygen on at 3 liter/minute via nasal cannula. Continue two plus edema right foot. Resident repositioned every two hours. Head of bed elevated with pillows behind head/neck. Signed licensed nurse/operator B. The record lacked documentation of pressure on bottom, symptoms, other indications of illness or injury including the date, time of occurrence, actions taken and results of actions taken. No further documentation in notes until 3/30/19 3/30/19 7:00 a.m. to 8:00 p.m. Resident continues to be in bed with brace and wrap to	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 31	S5251		

right leg in place. Resident turned slightly to help with pressure relief for buttocks with right leg straight. Staff continues to feed resident. Resident wanting to get up out of bed and into recliner. Staff continued to remind her that she needs to let leg heal first. Signed licensed nurse F.

3/31/19 7:00 a.m. to 8:00 p.m. Resident continued bed rest. Leg continued with brace and wrap to right leg. Turned and repositioned slightly to relieve pressure off buttock. Have maintained keeping leg straight throughout this shift. Signed licensed nurse F.

The record lacked documentation of what leg looked like, what foot/heels looked like, what buttocks looked like, actions taken, and results of actions taken.

No documentation until 4/2/19.

4/2/19 2:15 p.m. Nurse for physician stated if could arrange for resident to come to appointment on gurney would bed best way for appointment. Signed licensed nurse/operator B.

4/3/19 at 10:15 p.m. Left and right heel blackened like blood blister appearance. Complained of pain on right heel, both heels off loaded. 3 Centimeter (CM) in diameter on both heels. Open area noted to left buttock 3 1/2 CM in diameter. Call placed to medical care provider to report. Orders to apply barrier prep to left heel after cleaned with wound cleanser cover with meplix dressing. Change daily and as needed. Cleanse left buttock with would cleanser and apply meplix every day and as needed. Barrier prep to right heel every day after cleansed with wound cleanser. Signed licensed nurse/operator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 32 B. 4/3/19 at 10:30 a.m. Family notified of new orders for skin break down on both heels and buttocks. Family stated, "yea, I was worried about that as she had a spot on left heel at the hospital. Off-loading feet every two hours while leg remain straight/immobile. Removed ace wrap after opening brace. Signed licensed nurse/operator B. The record lacked documentation of all incidents, signs/symptoms and other indications of illness or injury including the date, time of occurrence, actions taken and results of actions taken. No further documentation until 4/7/19. 4/7/19 2:00 a.m. Staff called this nurse due to complaint of back pain. Norco 5/325 MG given and repositioned. Dressings to heels and buttocks intact, off loaded heels and put pillow under buttocks. Signed operator/RN. 4/7/19 3:00 a.m. Stayed to be sure pain medication effective and made comfortable. Oxygen saturation decreased to 72 %. Has shallow breathing and lung sounds diminished throughout. Put on mask as oxygen saturations continue to be in 80's. Put oxygen up to 5 liters/minutes. Called family to notify of resident condition and asked if wanted to send resident to hospital. Family was hesitant due to resident's condition from previous post-surgery. Physician requested resident be sent to hospital via non-emergency transfer. at 7:30 a.m. resident transferred. Signed operator/RN.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 33 4/11/19 2:45 p.m. Resident returned to facility by ambulance with diagnoses pneumonia. Stitches (staples) removed from right knee incision at the hospital. Brace on and heels medicated and wrapped. Heels off loaded from bed. Blister tip of right toe. Stated is glad to be back home. Signed operator/RN. 4/13/19 8:00 a.m. to 8:00 p.m. Resident resting and turned every two hours with heels off loaded. Signed licensed nurse F. 4/15/19 8:00 p.m. "Girls assisting resident getting ready for bed. Discussed she could have brace off for the night. She chose to leave it on." Signed operator/RN. 4/16/19 (no time) Received a call at 2:45 a.m. that resident couldn't get comfortable and complained of left leg pain. This nurse came to facility and administered hydrocodone/acetaminophen 5/325 MG for pain. Resident requested to have brace removed. Repositioned again. At 3:30 a.m. resting. Signed operator/RN. 4/16/19 (no time) Received orders from hospice. Right leg brace to be removed greater than 12 hours 24 hours a day. Removed brace from bed to allow adequate movement and circulation to skin. Change linen as necessary from perspiration to avoid additional skin break down. Signed licensed nurse C. The record lacked documentation of signs/symptoms and other indications of illness or injury including the date, time of occurrence, actions taken and results of actions taken. No further documentation about skin break down	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 34 in nurses notes. Written statement from licensed nurse C on 5/9/19 at 10:00 p.m. stated did not assess resident for skin break down upon return from hospital but did assess skin on 4/3/19. Interview on 5/6 19 at 1:00 p.m. with certified staff D stated tried to reposition resident #100 from side to side without moving right leg when first came home from hospital. Unable to put on side due to keeping right leg straight. 5/6/19 at 2:55 p.m. observed certified staff D and E transfer resident #100 from bed to recliner. Staff pulled covers back to place mobilizer under resident's right leg. Observed 1/2 side rails up on side of both sides of bed. Noted a staple in healed incision on right leg knee area. Staff certified staff stated had not seen it before. Left heel stuck to pad under it and pulled off during transfer. Noted black dried area with blister on right and left heels. Approximately 3 CM in diameter. Observed blood coming from two blisters on left forearm. Certified staff D and E confirmed left arm bleeding from dark blister on arm. Sling placed under resident while staff carefully transferred resident from bed to recliner. Feet elevated up off foot rest with pillows. Resident made comfortable. Interview on 5/6/19 at 4:20 p.m. with licensed nurse/operator B stated hospice providing wound care and did not document what wound looked like. Home health nurse G stated checked resident #100's skin and stated no skin break down upon return from hospital. Since home health nurse stated no skin break down he/she did not assess skin after return from hospital.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5251	Continued From page 35 Licensed nurse/operator B also stated was not aware resident had a staple in healed incision on right leg or that an assessment of side rail bed assistive device required. The record lacked an assessment to verify the bed assistive device was not a restraint, the 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 3/4 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. For resident #100, the operator/RN failed to ensure the resident record included documentation of all incidents including the date, time, actions taken, and results of actions taken.	S5251		
S5315 SS=D	26-42-205 (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	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5315	Continued From page 36 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 home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home 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 home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The facility identified a census of 7 residents. The sample included 3 residents. Based on observation and interview for 1 (#100) of 3 residents sampled, the licensed nurses and medication aides failed to ensure all medications securely and properly stored in accordance with	S5315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B096017	A. BUILDING: _____ B. WING _____	C 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HOME	419 N PACIFIC OXFORD, KS 67119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5315	Continued From page 37 manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations. Findings included: - Tour of medication room on 5/6/19 at 1:10 p.m. with licensed nurse/operator B revealed used novolog insulin pen. The insulin lacked the date opened or used. Interview with licensed nurse/operator B confirmed the insulin pen lacked date opened or used. For resident #100, the licensed nurses and medication aides failed to ensure all medications securely and properly stored in accordance with manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S5315		