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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey and complaint investigation #138200 for the above named home plus facility conducted on 2/13/19, 2/14/19, 2/18/19, 2/19/19 and 2/20/19.	S 000		
S5015 SS=F	26-42-101(c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the home; (2) implementing operational policies and procedures for the home; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: KAR 26-42-101 (c)(3) The facility reported a census of 7 residents on 2/13/19 and 8 residents prior. Based on observation, interview and record review licensed nurse/operator C failed to authorize, in writing, a responsible employee who is 18 years old or older to act on the operator's behalf in the absence of the operator with the potential to affect all 8 residents. Findings included: - Observation on 2/13/19 during the initial tour starting at 12:39 AM revealed no written notice	S5015		

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

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S5015	Continued From page 1 posted for which employee acted on behalf of the operator in the operator's absence. Interview on 2/13/19 at 12:57 PM with licensed nurse/operator C revealed he/she was on vacation and absent from the facility approximately 1/26/19 until he/she returned on 2/4/19. Review of the posted Policy and Procedures book located at the entrance on 2/14/19 at 1:10 PM revealed a page which listed sister facilities and who would act on the behalf of the operator in the absence. The sheet did not include the above-named home plus. Interview with licensed nurse/operator C on 2/14/19 at 1:30 PM confirmed he/she had failed to authorize, in writing, a responsible employee to act on behalf of the operator in his/her absence. Licensed nurse/operator C failed to authorize, in writing, a responsible employee who is 18 years old or older to act on the operator's behalf in the absence of the operator with the potential to affect all 8 residents.	S5015		
S5026 SS=J	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.	S5026		

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S5026	Continued From page 2 This REQUIREMENT is not met as evidenced by: KAR 26-42-101 (f)(1)(A) The facility reported a census of 7 residents. The sample included 3 residents and 2 focused reviews for safety. Based on observation, interview and record review licensed nurse/operator C failed to ensure resident (#312) remained free from physical abuse during an incident between resident #312, certified medication aide (CMA) B and certified nursing assistant (CNA) A. On 1/29/19 CMA B failed to take appropriate actions to redirect the resident which further excited the resident to strike out at CMA B then CNA A failed to take appropriate actions by grabbing the resident's arm with both his/her hands and a strong enough pulling motion to cause the resident to circle back to the right, stumble into a table, chair and then fall onto the floor while CNA A maintained the grip on the resident's right arm. The operator further failed to thoroughly investigate the incident and put measure in place to protect resident #312 from further potential abuse. These failures placed resident #312 in immediate jeopardy for harm, injury or death. Findings included: - Observation during the initial tour on 2/13/19 at 12:41 PM of resident #312's room revealed the resident's room had some of the resident's belongings piled on the bed and personal belongings remained on the wall. Certified nursing assistant F reported the resident had passed away that morning.	S5026		

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S5026	Continued From page 3 Record review revealed the resident admitted to the facility on 1/14/19 with diagnoses of Alzheimer's, depression and gout. The admission functional capacity screen (FCS) dated 1/11/19 identified the resident with short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting and eating and was independent with transfer, walking and mobility. He/she had impaired communication rarely or never understood others verbal information but was sometimes understood with self-expression. Under current or recent problems and risks the resident had impaired vision, impaired decision making, socially inappropriate/disruptive behavior with possibility of agitation. The negotiated service agreement/health care services (NSA/HCS) dated 1/11/19 indicated the facility provided 1 staff assistance with bathing, dressing, oral care and toileting. The resident independently transferred and ambulated. Under special risks he/she needed routine night checks. Under management of behavioral symptoms licensed nurse/operator C marked the preprinted interventions of redirection, distraction or music therapy, management of elopement risk/monitor doors/exits and orientate to person, place and times as needed. The NSA/HCS lacked identification of the socially inappropriate/disruptive behavior with possibility of agitation and interventions or services needed for management of these behaviors. Review of the nursing assessment dated 1/14/19 indicated the resident needed assistance with activities of daily living (ADLs) but independent	S5026		

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with walking. Under the comments - resident has severe dementia/Alzheimer's, unable to put complete sentences together or comprehend simple commands, talks gibberish most of the time and wanders around.

Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident.

The single sheet undated care plan sheet directed staff to monitor while eating as he/she may try to put wrappers in his/her mouth, needed assistance of 1 staff with bathing, dressing, oral care and toileting and independent with transfers and mobility. Additional comments included resident wanders around frequently and directed staff to always know where the resident is, keep an eye on him/her, and watch for wandering into other resident's rooms. He/she prefers to go to bed around 9:00 PM and required frequent night checks. Resident has severe dementia/Alzheimer's and can get irritated at times - try redirection or distraction therapy.

Review of the daily shift to shift report sheets between 1/14/19 and 2/13/19 revealed the following documentation:
1/14/19 - New resident (#312) need to ask him/her to go to the bathroom frequently
1/15/19 - up all night
1/18/19 - stayed in room wandering about - wandering and finally to bed at 12:45 AM
1/19/19 - requires frequent supervision - up all night
1/20/19 - resident urinated in trash can, was combative, tearing up his/her room and slept in recliner for about 4 hours

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1/23/19 - up and around all day, broke a doorknob and threw lots of punches
Note: Shift to shift report sheet updated next to resident #312 name to state: wanders, elopement risk and watch for agitation
1/26/19 - resident gave him/herself a skin tear on his/her left hand, very agitated all day and broke closet doors 1/27/19 - 3rd person to be with resident and he/she must be kept out of other rooms. Very violent and combative with family member of the resident
1/29/19 - dangerously aggressive, fell because he/she tried to hit staff and had to be pulled away. (later identified as certified staff A and B.

Review of the comments book between 1/14/19 and 1/29/19 revealed:
1 undated entry that reflected resident was resistant to changing soiled clothes, urinated on the floor and talked to self.
1/18/19 7:00 PM wandering and rearranging everything, sitting out in TV room or dining room with failed attempts to get him/her in bed. At 12:45 AM after he/she dump salt everywhere the resident finally got in bed but would still not change his/her clothes.
1/29/19 without a time - moved dresser out of resident's room as he/she had pulled the dresser over again. He/she broke the TV and family took it home.

Nurses Notes documented:

Review of the resident's record revealed no documentation in the nursing notes about skin tear noted on 1/26/19, violent or combative behavior with the family member of the resident on 1/27/19, or the incident with Certified Staff A and B on 1/29/19.

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1/30/19 at 10:37 PM by licensed nurse E, "notified by staff patient was found on the floor in room. On arrival staff had placed patient back in bed. Patient has diminished breath sounds on right, patient winces when right ribs palpated. Notified family member who stated patient seemed like he/she had pain in right ribs this morning when he/she saw the resident. [Licensed nurse E] called emergency medical services (EMS) for transport to emergency room (ER)."

The record lacked any reports, labs or X-rays performed at the hospital on 1/30/19.

Note: record lacks documentation of return to the facility from the emergency room with the next note dated 1/31/19 at 11:39 AM.

1/31/19 at 11:39 AM phone call from the physician's nurse which indicated the physician was aware of the resident's trip to the emergency department last night. Informed the physician's nurse the resident was sleeping today; no aggressive behaviors and the nurse indicated the physician said next step was Haldol and call if needed.

2/1/19 at 10:06 AM licensed nurse G wrote he/she received a call from facility staff about the resident throwing breakfast plate and broke a lamp. Nurse G instructed the CMA to give an Ativan PRN (as needed). At 10:09 AM nurse G called the physician's office and asked for the Haldol order.

2/1/19 at 8:10 PM licensed nurse G received a phone call from staff the resident had shut the room door in staff's face and then the staff heard a thud and found the resident on the floor on his/her back. Nurse G and staff were able to

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S5026	Continued From page 7 assist the resident to get up and the resident ambulated without difficulty. 2/4/19 (no time indicated) licensed nurse/operator C wrote resident now on Haldol and Seroquel due to extremely aggressive behaviors. Resident had hit staff, broke items in the house, went in and out of other resident's rooms and knocked over furniture. With the addition of Haldol, the resident is calmer and resting for longer periods of time and has only shown a small amount of aggression when prompted to use the bathroom. 2/5/19 (no time indicated) licensed nurse/operator C wrote resident more sleepy today and required assistance with all transfers, had to be prompted to eat and drink. 2/6/19 (no time indicated) licensed nurse/operator C wrote resident remains sleepy - does get combative when turning or changing brief. 2/7/19 at 12:10 PM ... resident had a coughing spell, lung sounds with Rhonchi and oxygen saturation dropped into the 80s with heart rate of 120 and blood pressure 90/60 ... resident sent to ER by EMS for evaluation. 2/7/19 at 6:30 PM licensed nurse/operator C wrote resident back from ER with diagnosis of pneumonia. The family had decided to start Hospice care services to evaluate on 2/8/19 ... 2/8/19 at 4:30 AM licensed nurse/operator C wrote resident more awake and starting to get restless and verbal ... 2/8/19 (no time indicated) ... resident continues to be awake and restless in bed.	S5026		

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S5026	Continued From page 8 2/12/19 at 8:45 AM resident unresponsive, eyes opened, glassy and fixed. Resident is febrile with tachycardia and tachypnea. Oxygen on at 2 liters per minute ... educated family and staff on end of life decline with comfort measures. On 2/14/19 the surveyor requested licensed nurse/operator C obtain the hospital record and X-ray report for the visit on 1/30/19. The X-ray report of 1/30/19 revealed a questionable minimally displaced posterior right 9th rib fracture with a new coarse right basilar reticulation, suspicious of infection or aspiration or contusion could appear similar. On 2/13/19 at 12:57 PM licensed nurse/operator C reported they had an aggressive resident who was trying to strike an employee and another employee intervened and indicated the facility had video footage of the incident. He/she said when the resident came he/she just wandered then he/she became more aggressive and wandering into other rooms so licensed nurse/operator C added another staff member during the period and contacted the physician for medication adjustment. Licensed nurse/operator C further stated he/she did not report the incident as a potential allegation of abuse. Review of the video footage with licensed nurse/operator C on 2/13/19 at 1:52 PM revealed a recording of an incident on 1/29/19 beginning at 6:18 PM with resident #312 calmly and peaceably ambulating next to the wall by the patio door towards the kitchen counter with certified medication aide (CMA) B. Resident #410 sat at the dining room table with his/her family member with beverages in front of him/her. Once resident #312 got to the kitchen counter CMA B sat in a chair at the counter, the resident placed his/her	S5026		

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hands on the counter and moved his/her left leg outward towards CMA B in a side-kicking motion. The resident then turned towards the dining table, appeared to be talking and moved his/her arms in circles out to the side while walking towards the table. When he/she got to the table he/she played with his/her pants and pockets, appeared to think about moving out a chair to sit and then reached across the table and took the drinking glass of resident #410 into his/her left hand. At that time CMA B got up and rushed to resident #312. CMA B grabbed for the drinking glass and grasped the resident's right arm. The resident turned his/her head toward CMA B and gave him/her an aggressive facial expression. CMA B pulled the resident's right arm slightly back and attempted to reach the drinking glass again. Meanwhile, the resident moved his/her left hand with the drinking glass further from his/her body outward to the left. The resident attempted to drink from the glass and CMA B again pulled on the resident's right arm and attempted to get the drinking glass. On the 3rd attempt to get the drinking glass from the resident the resident turned, swung with a slapping motion at CMA B's hands and arms with his/her right open hand and still held the drinking glass in the left hand. CMA B failed to put his/her arms/hands into a neutral non-aggressive position and move away from the resident to deescalate the behavior. CMA B remained in close proximity to the resident while taking a few steps back. The resident continued to advance and slap at CMA B's hands/arms as CMA B backed up towards the wall. The video reflected while CMA B had a wall at his/her back but not pinned to the wall. He/she had space to maneuver side ways to avoid the resident's advance. At this point, CNA A rapidly came from the kitchen area, grabbed the resident's right arm with both his/her hands and pulled forcefully

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enough to cause the resident to circle/stumble around to the right while CMA B continued to try to get the drinking glass which caused spilling of ice and water onto the floor. CNA A maintained both hands on the resident's right arm and pulled in a continuous back circle motion towards the dining table. The resident struck the dining room table with enough force for the table to move at least 6 inches. CNA A continued to grasp the resident's right arm with both hands as the resident had a downward trajectory where he/she also collided with a chair knocking it over and landed face forward on the floor. At this time, CNA A let go of the resident's arm. The resident got him/herself up onto all fours then to his/her knees at which time he/she reached out with the right arm for assistance from CNA A to stand. Once standing the resident was calm, turned and wandered away.

Interview on 2/13/19 at 1:08 PM with CMA D revealed the resident had Alzheimer's and would get aggressive at times depending on the approach and he/she did not redirect easily. He/she said staff had to stay with the resident 1-on-1. CMA D reported the resident always wandered since the time of admission but at the end of January the resident started declining and fell several times. When asked about dementia training or training to manage aggressive behavior, CMA D stated he/she had not received any training from this facility on dementia approaches or behaviors.

Interview on 2/13/19 at 2:57 PM with CMA B revealed when the resident first admitted to the facility he/she would walk around and mumble to him/herself but did not talk. He/she reported staff would follow the resident to make sure he/she did not knock over lamps or get into stuff. When the

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resident fidgeted with his/her pants staff knew to take him/her to the bathroom. However, the resident would randomly urinate in places because he/she did not know what he/she was doing. The resident would stick anything in his/her mouth, so staff made sure he/she only had food items at the table. He/she confirmed what the video on 1/29/19 revealed of his/her attempts to get the drinking glass from the residents and grabbing the resident's arm. He/she did not know how to handle the aggressive resident, expressed fear of being hit and he/she backed away but did not leave the resident to calm down. When asked about dementia training or training to manage aggressive behavior, CMA B reported when he/she began employment he/she received hands on training with residents and was taught how to use the computer for medication administration. He/she reported no training for dementia was provided at the time of hire. When asked if he/she had any dementia training when the resident admitted or after displaying the aggressive behavior he/she reported no real training at the meetings they talked about the resident's behaviors but did not really receive training or guidance on how to handle the resident's agitation/aggressive behavior. He/she had not received any training for dementia, behaviors and approaches since the incident.

Interview on 2/14/19 at 3:52 PM CNA F reported no training on dementia/behaviors at this facility. He/she reported in staff meetings would talk about what we could do to improve, what might happen at the facility or resident concerns. He/she said coworkers might discuss behaviors of a particular resident and talked about what can a person do for a resident with dementia. He/she reported some training in the January staff meeting on dementia. He/she reported the staff

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had a meeting prior to resident admission about how to handle wandering behavior. He/she said in the first week after resident #312 was admitted, he/she began having aggressive/agitated behavior. He/she said the facility no longer had any residents at the facility with aggressive behaviors since resident #312 passed away on the morning of 2/13/19.

Review of the facility's policy for Abuse, Neglect and Exploitation dated 10/1/18 revealed a definition of abuse as an act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a resident, including: infliction of physical or mental injury ... Unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm a resident ... A threat or menacing conduct directed toward a resident that results or might reasonably be expected to result in fear or emotional or mental distress to a resident. The company will not allow the use of verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion. The policy indicated all allegations of abuse, neglect, or exploitation will be investigated and reported immediately to the administer or operator ...During an investigation, any licensed nurse or medication aide or nurse aide that is under investigation may be suspended from work without pay until a conclusion is determined.

For resident #312, licensed nurse/operator C failed to ensure the resident remained free from verbal, mental or physical abuse during an encounter between resident #312 and certified medication aide (CMA) B and certified nursing assistant (CNA) A. On 1/29/19 CMA B failed to take appropriate actions to redirect the resident which further excited the resident to strike out at

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S5026	Continued From page 13 CMA B then CNA A failed to take appropriate actions by grabbing the resident's arm with both his/her hands and a strong enough pulling motion to cause the resident to circle back to the right, stumble into a table, chair and then fall onto the floor while CNA A maintained the grip on the resident's right arm. The operator further failed to thoroughly investigate the incident and put measure in place to protect resident #312 from further potential abuse. These failures placed resident #312 in immediate jeopardy for harm, injury or death. The jeopardy was removed on 2/12/19 when the resident became unresponsive.	S5026		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the	S5028		

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S5028	Continued From page 14 department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101 (f)(3)(A)(B)(C) The facility reported a census of 7 residents. The sample included 3 residents and 2 focused reviews for safety. Based on observation, interview and record review licensed nurse/operator C failed to ensure staff reported a staff to resident altercation to the state agency within 24 hours, failed to start an investigation, failed to immediately take actions to prevent further potential abuse while an investigation was in progress and failed to conduct a thorough investigation within 5 working days of the initial report for 1 of 5 residents sampled (#312). Licensed nurse/operator C also failed to ensure staff reported an incident/fall to a nurse on staff and failed to investigate the resident's ankle fracture to rule out abuse for 1 of 5 residents sampled (#414). Findings included: - Observation during the initial tour on 2/13/19 at 12:41 PM of resident #312's room revealed the resident's room had some of the resident's belonging piled on the bed and personal belongings remained on the wall. Certified nursing assistant F reported the resident had passed away that morning.	S5028		

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S5028	Continued From page 15 Record review revealed resident #312 admitted to the facility on 1/14/19 with diagnoses of Alzheimer's, depression and gout. The admission functional capacity screen (FCS) dated 1/11/19 identified the resident with short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting and eating and was independent with transfer, walking and mobility. He/she had impaired communication rarely or never understood others verbal information but was sometimes understood with self-expression. Under current or recent problems and risks the resident had impaired vision, impaired decision making, socially inappropriate/disruptive behavior with possibility of agitation. The negotiated service agreement/health care services (NSA/HCS) dated 1/11/19 indicated the facility provided assistance of 1 staff with bathing, dressing, oral care and toileting. The resident independently transferred and ambulated. Under special risks he/she needed routine night checks. Under management of behavioral symptoms licensed nurse/operator C marked the preprinted interventions of redirection, distraction or music therapy, management of elopement risk/monitor doors/exits and orientate to person, place and times as needed. The NSA/HCS lacked identification of the socially inappropriate/disruptive behavior with possibility of agitation and interventions or services needed for management of these behaviors. Review of the nursing assessment dated 1/14/19 indicated the resident needed assistance with activities of daily living (ADLs) but independent	S5028		

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with walking. Under the comments - resident has severe dementia/Alzheimer's, unable to put complete sentences together or comprehend simple commands, talks gibberish most of the time and wanders around.

Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident.

The single sheet undated care plan sheet directed staff to monitor while eating as he/she may try to put wrappers in his/her mouth, needed assistance of 1 staff with bathing, dressing, oral care and toileting and independent with transfers and mobility. Additional comments included resident wanders around frequently and directed staff to always know where the resident is, keep an eye on him/her, and watch for wandering into other resident's rooms. He/she prefers to go to bed around 9:00 PM and required frequent night checks. Resident has severe dementia/Alzheimer's and can get irritated at times - try redirection or distraction therapy.

On 2/13/19 at 12:57 PM licensed nurse/operator C reported they had an aggressive resident who was trying to strike an employee when another employee intervened and indicated the facility had video footage of the incident. Licensed nurse/operator C reported being made aware of the on 2/5/19 at about 10:00 AM. He/she then reviewed the video and reported being disturbed by the altercation but he/she did not report the incident as a potential allegation of abuse. He/she reported talking to the staff involved but did not have any written statements. He/she reported the incident occurred on 1/29/19 while licensed

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nurse/operator C was absence from the facility and the nurse on-call was at the facility to evaluate the resident.

Review of the video footage with licensed nurse/operator C on 2/13/19 at 1:52 PM revealed a recording of an incident on 1/29/19 beginning at 6:18 PM with resident #312 calmly and peaceably ambulating next to the wall by the patio door towards the kitchen counter with certified medication aide (CMA) B. Resident #410 sat at the dining room table with his/her family member with beverages in front of him/her. Once resident #312 got to the kitchen counter CMA B sat in a chair at the counter, the resident placed his/her hands on the counter and moved his/her left leg outward towards CMA B in a side-kicking motion. The resident then turned towards the dining table, appeared to be talking and moved his/her arms in circles out to the side while walking towards the table. When he/she got to the table he/she played with his/her pants and pockets, appeared to think about moving out a chair to sit and then reached across the table and took the drinking glass of resident #410 into his/her left hand. At that time CMA B got up and rushed to the resident #312. CMA B grabbed for the drinking glass and grasped the resident's right arm. The resident turned his/her head toward CMA B and gave him/her an aggressive facial expression. CMA B pulled the resident's right arm slightly back and attempted to reach the drinking glass again. Meanwhile, the resident moved his/her left hand with the drinking glass further from his/her body outward to the left. The resident attempted to drink from the glass and CMA B again pulled on the resident's right arm and attempted to get the drinking glass. On the 3rd attempt to get the drinking glass from the resident the resident turned, swung with a slapping motion at CMA B's

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hands and arms with his/her open right hand and still held the drinking glass in the left hand. CMA B failed to put his/her arms/hands into a neutral non-aggressive position and move away from the resident to deescalate the behavior. CMA B remained in close proximity to the resident while taking a few steps back. The resident continued to advance and slap at CMA B's hands/arms as CMA B backed up towards the wall. The video reflected while CMA B had a wall at his/her back but not pinned to the wall. He/she had space to maneuver side ways to avoid the resident's advance. At this point, CNA A rapidly came from the kitchen area, grabbed the resident's right arm with both his/her hands and pulled forcefully enough to cause the resident to circle/stumble around to the right while CMA B continued to try to get the drinking glass which caused spilling of ice and water onto the floor. CNA A maintained both hands on the resident's right arm and pulled in a continuous back circle motion towards the dining table. The resident struck the dining room table with enough force for the table to move at least 6 inches. CNA A continued to grasp the resident's right arm with both hands as the resident had a downward trajectory where he/she also collided with a chair knocking it over and landed face forward on the floor. At this time, CNA A let go of the resident's arm. The resident got him/herself up onto all fours then to his/her knees at which time he/she reached out with the right arm for assistance from CNA A to stand. Once standing the resident was calm, turned and wandered away.

Nurses Notes documented:

Review of the nursing notes between 1/14/19 and 2/12/19 revealed no documentation of the incident on 1/29/19 with certified staff A and B or

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a nurse assessment after the incident to rule out injury. The notes were dated 1/17/19 (no time indicated) resident having trouble sleeping at night and doing a lot of wandering - physician notified and medication adjusted. The next note was 1/30/19 at 10:37 PM by licensed nurse E, "notified by staff patient was found on the floor in room. On arrival staff had placed patient back in bed. Patient has diminished breath sound on right, patient winces when right ribs palpated. Notified family member who stated patient seemed like he/she had pain in right ribs this morning when he/she saw the resident. [Licensed nurse E] called emergency medical services (EMS) for transport to emergency room (ER)."

The record lacked any reports, labs or X-rays performed at the hospital on 1/30/19.

2/1/19 at 8:10 PM licensed nurse G received a phone call from staff the resident had shut the room door in staff's face and then the staff heard a thud and found the resident on the floor on his/her back. Nurse G and staff were able to assist the resident to get up and the resident ambulated without difficulty.

2/4/19 (no time indicated) licensed nurse/operator C wrote resident now on Haldol and Seroquel due to extremely aggressive behaviors. Resident had hit staff, broke items in the house, went in and out of other resident's rooms and knocked over furniture. With the addition of Haldol, the resident is calmer and resting for longer periods of time and has only shown a small amount of aggression when prompted to use the bathroom.

On 2/14/19 the surveyor requested licensed nurse/operator C obtain the hospital record and X-ray report for the visit on 1/30/19. The X-ray

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report of 1/30/19 revealed a questionable minimally displaced posterior right 9th rib fracture with a new coarse right basilar reticulation, suspicious of infection or aspiration or contusion could appear similar.

Interview on 2/13/19 at 2:57 PM with CMA B confirmed what the video on 1/29/19 revealed of his/her attempts to get the drinking glass from the residents and grabbing the resident's arm. He/she did not know how to handle the aggressive resident, expressed fear of being hit and he/she backed away but did not leave the resident to calm down.

Interview on 2/13/19 at 2:07 PM with CNA A reported on 1/29/19 responding to a coworker's call for help, saw the resident striking out at the coworker who was telling him/her to give the water back. CNA A confirmed grabbing ahold of the resident's arm and pulling him/her when the resident stumbled into and tripped over a chair. He/she reported the resident got up on his/her own and then acted like nothing had happened and went walking about again.

Interview on 2/14/19 at 2:30 PM with licensed nurse/operator C confirmed direct care staff A and B did not act appropriately with the resident and the incident needed to be investigated as possible abuse. He/she said licensed nurse E was at the facility and evaluated the resident and situation. He/she confirmed the resident's record lacked any documentation of the incident or a nurse assessment. He/she reported having some text messages while on vacation but due to a lack of cell phone service he/she did not get the messages until he/she returned on 2/4/19. He/she confirmed direct care staff A and B continued to work and provided care for the

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resident after the incident on 1/29/19 and the resident continued to display agitation/aggressive behaviors. He/she had no evidence an investigation was started or completed and had no written statements from the staff involved.

Review of the facility's policy for Abuse, Neglect and Exploitation dated 10/1/18 revealed a definition of abuse as an act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a resident, including: infliction of physical or mental injury ... Unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm a resident ... A threat or menacing conduct directed toward a resident that results or might reasonably be expected to result in fear or emotional or mental distress to a resident. The company will not allow the use of verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion. The policy indicated all allegations of abuse, neglect, or exploitation will be investigated and reported immediately to the administer or operator and to the state agency. The investigation shall include, but not limited to consultation with those individuals having knowledge of the facts of the particular case. Provide evidence the alleged violations were thoroughly investigated to the state agency, take measures to prevent further potential abuse, neglect or exploitation. Report the results of the investigation and maintain a written record of all investigations of reported abuse, neglect or exploitation. Take appropriate corrective actions if the alleged violations are substantiated. During an investigation, any licensed nurse or medication aide or nurse aide that is under investigation may be suspended from work without pay until a conclusion is determined.

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S5028	Continued From page 22 Licensed nurse/operator C failed to ensure staff reported a staff to resident altercation to the state agency within 24 hours, failed to start an investigation, failed to immediately take actions to prevent further potential abuse while an investigation was in progress and failed to conduct a thorough investigation within 5 working days of the initial report for this resident. - Record review for resident #414 revealed an admission date of 10/29/17 with diagnoses of anxiety, depression, hypertension and chronic pain. The annual functional capacity screen dated 10/25/18 revealed the resident had short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she required physical assistance with bathing, was at risk for falls or had an unsteady gait and used a walker. The negotiated service agreement/health care services (NSA/HCS) dated 10/25/18 indicated the resident received home health nursing services for management and changing of a supra pubic catheter. He/she needed stand by assistance with transfers and used a walker. He/she needed physical assistance of 1 staff with bathing twice awake. The NSA/HCS plan was amended on 2/9/19 for resident needing assistance with transfers, toileting, showers and ADLs (activities of daily living) at this time due to ankle pain. Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident.	S5028		

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S5028	Continued From page 23 The single sheet undated care plan sheet directed staff to assist the resident with bathing 2 times a week and provide stand by assistance with transfers PRN (as needed) with mobility by walker and stand by assist. The care plan sheet was updated on 2/9/19 for staff to help resident with ADLs (activities of daily living), transfers and toileting. Review of the nursing notes between 8/9/18 and 2/12/19 (last entry) revealed on 1/7/19 at 5:15 PM ... resident used a walker and asked for assistance when needed. On 2/7/19 (no time indicated) resident not feeling well today and having catheter issues with draining. Home health nurse came to facility and changed out catheter and irrigated catheter. ... resident taken to emergency room by family and returned with order for antibiotic to treat a urinary tract infection. On 2/8/19 at 5:00 AM resident reports feeling much better with clear urine flow noted from catheter. The next entry, 2/10/19 (no time indicated) nurse was informed the resident suffered a fall which resulted in a fracture to the right ankle and complaints of pain. Tramadol ordered ... educated resident and staff on using ice for 15-20 minutes intervals to relieve pain and rest. 2/11/19 (no time indicated) resident doing well this morning with tramadol PRN for pain control. Resident will follow up with orthopedic surgeon at a later date. Review of a staff communication book revealed an entry dated 2/10/19 resident #414 fell before/after the shower on 2/9/19 and the family member was called instead of notifying a nurse on staff. The resident fractured his/her ankle - he/she needs to use his/her scooter to get back/forth but wants to use the chair.	S5028		

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S5028	Continued From page 24 Interview on 2/14/19 at 11:55 AM with licensed nurse/operator C confirmed the record lacked X-ray results or any evidence of the injury. He/she reported the resident did not actually fall but twisted his/her ankle getting out of the shower. A request to review the investigation of the incident revealed he/she was not aware of an investigation but would check. He/she did not know if statements were obtained from the staff about the injury or cares with the bathing. He/she did not at this time know which staff provided assistance with the shower. At 12:49 PM, licensed nurse/operator C confirmed nothing was documented about the incident and there should have been. Review of X-ray results licensed nurse/operator C obtained on 2/14/19 at 1:11 PM revealed the right ankle had soft tissue swelling at the ankle, osseous fragmentation to the medial malleolus with relatively acute-appearance. Review of the facility's resident fall prevention procedures and policy dated 10/1/18 revealed a list of factors and possible interventions but failed to include procedures to follow when a fall occurs. Review of the facility's policy for Abuse, Neglect and Exploitation dated 10/1/18 revealed a definition of abuse as an act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a resident, including: infliction of physical or mental injury ... Unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm a resident ... A threat or menacing conduct directed toward a resident that results or might reasonably be expected to result in fear or emotional or mental distress to a resident. The company will not allow the use of verbal, mental, sexual, or	S5028		

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S5028	Continued From page 25 physical abuse, including corporal punishment and involuntary seclusion. The policy indicated all allegations of abuse, neglect, or exploitation will be investigated and reported immediately to the administer or operator. The investigation shall include, but not limited to consultation with those individuals having knowledge of the facts of the particular case. Provide evidence the alleged violations were thoroughly investigated and maintain a written record of all investigations of reported abuse, neglect or exploitation. Licensed nurse/operator C failed to ensure staff reported an incident/fall with possible injury to a nurse on staff and failed to conduct an investigation of the resident's fractured ankle to rule out abuse.	S5028		
S5095 SS=E	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (d) The facility reported a census of 7 residents. The sample included 3 residents and 2 focused reviews for safety. Based on interview and record review licensed nurse/operator C failed to ensure 2 of 5 sampled residents' (#312 and #410) functional capacity screening accurately reflected	S5095		

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the resident's functional capacity regarding falls/unsteadiness or wandering behavior.

Findings included:

- Record review revealed resident #312 admitted to the facility on 1/14/19 with diagnoses of Alzheimer's, depression and gout.

The admission functional capacity screen (FCS) dated 1/11/19 identified the resident with short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting and eating and was independent with transfer, walking and mobility. He/she had impaired communication rarely or never understood others verbal information but was sometimes understood with self-expression. Under current or recent problems and risks the resident had impaired vision, impaired decision making, socially inappropriate/disruptive behavior with possibility of agitation.

Review of the nursing assessment dated 1/14/19 indicated the resident needed assistance with activities of daily living (ADLs) but independent with walking. Under the comments - resident has severe dementia/Alzheimer's, unable to put complete sentences together or comprehend simple commands, talks gibberish most of the time and wanders around.

Review of nursing notes dated 1/14/19 at 5:30 PM resident admitted to the facility with severe Alzheimer's and unable to put sentences together or understand verbal commands.

Interview on 2/13/19 at 1:08 PM with CMA D revealed the resident had Alzheimer's and would

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get aggressive at times depending on the approach and his/she did not redirect easily. He/she said staff had to stay with the resident 1-on-1. CMA D reported the resident always wandered since the time of admission but at the end of January the resident started declining and fell several times. When asked about dementia training or training to manage aggressive behavior, CMA D stated he/she had not received any training from this facility on dementia approaches or behaviors.

Interview on 2/13/19 at 2:57 PM with CMA B revealed when the resident first admitted to the facility he/she would walk around and mumble to him/herself but did not talk. He/she reported staff would follow the resident to make sure he/she did not knock over lamps or get into stuff.

Interview on 2/14/19 at 2:35 PM licensed nurse/operator C confirmed the FCS did not reflect the resident's wandering behavior present at the time of admission and it should have been marked.

Licensed nurse/operator C failed to ensure this resident's functional capacity screening accurately reflected the resident's functional capacity regarding wandering behavior.

- Record review for resident #410 revealed an admission date of 9/21/18 with diagnoses of dementia, pacemaker, atrial fibrillation and history of lung cancer.

Review of the admission functional capacity screening (FCS) dated 9/20/18 revealed the resident had short-term and long-term cognition deficit, memory recall deficit and impaired decision making. He/she needed physical

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S5095	Continued From page 28 assistance with bathing and transfers PRN (as needed). He/she had impaired vision and hearing with impaired decision making but was not marked with falls, unsteadiness. The nursing assessment dated 9/21/18 indicated the resident walked around the facility using a cane for balance, had an unsteady gait at times and needed standby assistance PRN. Nursing notes dated 9/21/18 at 4:00 PM indicated the resident admitted to the facility with history of dementia. Resident ambulates with a cane and is occasionally unsteady when walking into his/her room. Interview on 2/14/19 at 2:35 PM with licensed nurse/operator C confirmed the FCS did not accurately reflect the resident's fall risk and unsteadiness. Licensed nurse/operator C failed to ensure this resident's functional capacity screening accurately reflected the resident's functional capacity regarding wandering behavior.	S5095		
S5155 SS=G	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		

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S5155	Continued From page 29 This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a) The facility reported a census of 7 residents. The sample included 3 residents and 2 focused reviews for safety. Based on observation, interview and record review licensed nurse/operator C failed to provide or coordinate the provision of necessary health care services that meet the needs for 5 of 5 sampled residents (#312, #364, #378, #410 and #414) and were in accordance with the functional capacity screening and the negotiated service agreement related to wandering behavior, falls, bed rail, pressure ulcer and other skin conditions such as cellulitis/edema. Resident #364 dependent on staff for transfers and activities of daily living, had an illness and stayed in bed more. The negotiated service agreement/health care service (NSA/HCS) plan failed to identify the resident's skin risk or interventions to reduce the risk of impaired skin integrity. The resident developed a blood spot on the left heel on 1/18/19 with no nurse assessment or physician notification. The record lacked evidence of ongoing monitoring for healing and no revision to the NSA/HCS to promote healing or to reduce the risk of further worsening or development of other areas. Findings included: - Record review for resident #364 revealed an admission date of 9/12/18 with diagnoses of Alzheimer's, normal pressure shunt placement, hypothyroidism and high cholesterol. Review of the admission functional capacity screening dated 9/12/18 revealed the resident	S5155		

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had short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she required physical assistance with bathing, dressing, toileting, transfers, ambulation and mobility. He/she had unsteadiness on his/her feet, used a walker only to stand and a wheelchair for mobility.

The negotiated service agreement/health care services (NSA/HCS) dated 9/12/18 indicated facility staff would provide 2 staff assistance with bathing, dressing, toileting, transfers and using the walker only to stand. The section for special risks was marked for need of routine night checks and no other fall risk management. The section for management of skin risk contained a typed listing of possible interventions with none marked. The NSA/HCS was amended on 10/8/18 with may use body alarm for resident safety at bedtime continuously. The NSA/HCS was amended on 2/1/19 to include resident on Hospice care, in a hospital bed, staff to use a lift with 2 assists to get resident out of the bed PRN (as needed). Hospital bed with bedrails. The NSA/HCS plan lacked an amendment to address the development of a pressure ulcer on the resident's left heel on 1/18/19.

Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident.

The single sheet undated care plan sheet without any dated changes directed staff to provide 2 staff assistance for bathing, dressing, toileting, transfers and to use a body alarm at bedtime continuous. He/she was identified as a fall risk without any interventions to reduce the fall risk.

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He/she was also marked with skin risk and no interventions to reduce those risks.

Nursing notes documented between 9/12/18 (admission) to 2/02/19 (last entry):

10/09/18 at 2:30 PM ... resident uses walker to stand with assist of 2 staff but was wheelchair bound after sitting down, skin good, and had a very good appetite. Resident had gotten out of bed without staff assistance twice and staff placed a body alarm for safety.

1/07/19 at 4:00 PM resident battling some coughing and congestion the past week or so and not wanted to get out of bed as much. His/her vital signs remain stable and appetite remains good. He/she continues to need assistance with all activities of daily living and 2 assists for transfers. Resident slightly weaker than normal.

1/08/19 at 8:30 AM resident started running a fever with Tylenol given and relief obtained. Resident continues to cough and have congestion the physician was notified.

1/09/19 (no time indicated) the durable power of attorney (DPOA) preferred not to have the resident on an antibiotic and to let nature take its course...

1/11/19 at 4:00 PM licensed nurse/operator C spoke with the DPOA after speaking with the resident's physician who indicated the resident would have other signs/symptoms of deterioration when the time comes. Resident's DPOA agreed to start antibiotic if resident becomes ill again.

Note: The next note was 1/27/19 - none of the nursing notes between 1/18/19 and last entry

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dated 2/2/19 or any documents within the resident's medical records reflected a nurse assessment or notification of the physician about the pressure ulcer on the resident's left heel.

Review of the physician orders revealed no treatment orders for the pressure ulcer on the resident's left heel.

On 2/13/19 review of the staff communication book revealed an entry dated 1/18/19 about the resident assisted to bed and still has a blood spot on the left heel - pillow was put under the foot. Note: This is not reflected in the nursing notes or amended on the NSA/HCS to promote wound healing and reduce the risk of further skin breakdown. The national pressure ulcer advisory panel defines a pressure ulcer as a pressure injury of localized damage to the skin and underlying soft tissue usually over a bony prominence... The injury can present as intact skin or an open ulcer and maybe painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 2 pressure injury is a partial-thickness skin loss ... the wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister... these injuries commonly result from adverse microclimate and shear of the skin over the pelvis and shear in the heel. Wikipedia described a blood blister may occur with friction caused by constant rubbing of skin against a surface.

Review of the shift to shift report sheets revealed on 1/14/19 the resident received a shower and no documentation of a skin integrity alteration. On 1/15/19 washed resident's linen and no indication of a skin alteration. On 1/18/19 kept foot completely off the bed.

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S5155	Continued From page 33 Review of the record revealed no investigation into causal factors of the pressure ulcer development on the left heel. Note: none of the nursing notes between 1/18/19 and last entry dated 2/02/19 or any documents within the resident's medical records reflected a nurse assessment or notification of the physician about the pressure ulcer on the resident's left heel. Review of the physician orders revealed no treatment orders for the pressure ulcer on the resident's left heel. On 2/14/19 at 9:25 AM the resident declined to allow the surveyor to observe routine incontinent care and repositioning. While the surveyor spoke with the resident certified medication aide (CMA) L pulled the covers off the resident's feet. Observation revealed the left heel had a covering, was in a foam protector and elevated on a pillow. Interview on 2/14/19 at 9:25 AM with CMA K revealed the resident had an illness in January 2019 and was staying in bed more. He/she developed the area on the left heel from crossing his/her feet. CMA K reported the heel had new skin forming. Interview on 2/14/19 at 2:30 PM with licensed nurse/operator C confirmed the NSA/HCS plan dated 9/12/18 failed to identify the resident's skin integrity risk and lacked an amendment after the development of the blood spot/pressure ulcer on the left heel. He/she could not confirm when the area actually developed, he/she had no investigation into causal factors and confirmed the record failed to any information about the	S5155		

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pressure ulcer or physician notification.

Licensed nurse/operator C failed to provide or coordinate the provision of necessary health care services that meet the needs for this resident and were in accordance with the functional capacity screening and the negotiated service agreement related to management of skin risk for this resident identified as at risk.

- Observation during the initial tour on 2/13/19 at 12:41 PM of resident #312's room revealed the resident's room had some of the resident's belonging piled on the bed and personal belongings remained on the wall. Certified nursing assistant F reported the resident had passed away that morning.

Record review revealed resident #312 admitted to the facility on 1/14/19 with diagnoses of Alzheimer's, depression and gout.

The admission functional capacity screen (FCS) dated 1/11/19 identified the resident with short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting and eating and was independent with transfer, walking and mobility. He/she had impaired communication rarely or never understood others verbal information but was sometimes understood with self-expression. Under current or recent problems and risks the resident had impaired vision, impaired decision making, socially inappropriate/disruptive of behavior with possibility of agitation. The FCS did not reflect the resident had wandering behavior.

The negotiated service agreement/health care services (NSA/HCS) dated 1/11/19 indicated the

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facility provided 1 staff assistance for bathing, dressing, oral care and toileting. The resident independently transferred and ambulated. Under special risks he/she needed routine night checks. Under management of behavioral symptoms licensed nurse/operator C marked the preprinted interventions of redirection, distraction or music therapy, management of elopement risk/monitor doors/exits and orientate to person, place and times as needed. The NSA lacked identification of the socially inappropriate/disruptive behavior with possibility of agitation and interventions or services needed for management of these behaviors nor did it include the resident's wandering behavior. The only amendment was dated 2/4/19 ok to use wheelchair for resident, staff assisting resident with feeding and 2 staff to assist resident with transfers.

Review of the nursing assessment dated 1/14/19 indicated the resident needed assistance with activities of daily living (ADLs) but independent with walking. Under the comments - resident has severe dementia/Alzheimer's, unable to put complete sentences together or comprehend simple commands, talks gibberish most of the time and wanders around.

Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident.

The single sheet undated care plan sheet directed staff to monitor while eating as he/she may try to put wrappers in his/her mouth, needed assistance of 1 staff with bathing, dressing, oral care and toileting and independent with transfers and mobility. Additional comments included

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resident wanders around frequently and directed staff to always know where the resident is, keep an eye on him/her, and watch for wandering into other resident's rooms. He/she prefers to go to bed around 9:00 PM and required frequent night checks. Resident has severe dementia/Alzheimer's and can get irritated at times - try redirection or distraction therapy. With no dated updates.

Review of the daily shift to shift report sheets between 1/14/19 and 2/13/19 revealed the following documentation:
1/18/19 - stayed in room wandering about - wandering and finally to bed at 12:45 AM
1/19/19 - required frequent supervision - up all night
1/20/19 - resident urinated in trash can, was combative, tearing up his/her room and slept in recliner for about 4 hours. - Note: no changes to the NSA/HCS to address his/her combative and destructive behavior
1/23/19 - up and around all day, broke a doorknob and threw lots of punches - Note: no changes to NSA/HCS to address aggressive striking out behaviors
Note: Shift to shift report sheet updated next to resident #312 name to state: wanders, elopement risk and watch for agitation
1/26/19 - resident gave him/herself a skin tear on his/her left hand, very agitated all day and broke closet doors. - Notes: no evidence in the record of investigation for causal factors of skin tear.
1/27/19 - 3rd person to be with resident and he/she must be kept out of other rooms. Very violent and combative with family member of resident - Note: no changes to NSA/HCS to address violent, combative, aggressive striking out behaviors
1/29/19 - dangerously aggressive, fell because

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he/she was trying to hit staff and had to be pulled away - Note: no changes to NSA/HCS to address violent, combative, aggressive striking out behaviors
2/01/19 - resident was in another resident's room and sat in his/her chair, resident fell twice at 8:40 PM and 10:51 PM (only the 8 PM fall was recorded in the nursing notes) - Note: no changes to NSA/HCS related to falls, no investigation into causal factors and no interventions to reduce the risk of further falls.
2/03/19 - resident was put in a chair now laying on the floor (no time indicated and not reflected in the nursing notes)
2/04/19 - resident on the floor a lot then in his/her chair (not recorded in record as falls or how the resident came to be on the floor)

Review of the comments book between 1/14/19 and 1/29/19 revealed:
1 undated entry that reflected resident was resistant to changing soiled clothes, urinated on the floor and talked to self. - Note: no changes to the NSA/HCS to address this behavior
1/18/19 7:00 PM wandering and rearranging everything, sitting out in TV room or dining room with failed attempts to get him/her in bed. At 12:45 AM after he/she dump salt everywhere the resident finally got in bed but would still not change his/her clothes. - Note: no changes to the NSA/HCS to address this behavior
1/29/19 without a time - moved dresser out of resident's room as he/she had pulled the dresser over again. He/she broke the TV and family took it home. - Note: no changes to the NSA/HCS to address this behavior

Nurses Notes documented:

Review of the resident's record revealed no

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documentation in the nursing notes about skin tear noted on 1/26/19, violent or combative behavior with the family member of a resident on 1/27/19, or the incident on 1/29/19 of hitting staff and being pulled away.

1/30/19 at 10:37 PM by licensed nurse E, "notified by staff patient was found on the floor in room. On arrival staff had placed patient back in bed. Patient has diminished breath sound on right, patient winces when right ribs palpated. Notified family member who stated patient seemed like he/she had pain in right ribs this morning when he/she saw the resident. Licensed nurse E called emergency medical services (EMS) for transport to emergency room (ER)." Note: the NSA/HCS lacked a revision to include the fall, an investigation of causal factors or interventions to reduce the risk of further falls.

The record lacked any reports, labs or X-rays performed at the hospital on 1/30/19.

Note: record lacks documentation of return to the facility from the emergency room with the next note dated 1/31/19 at 11:39 AM.

1/31/19 at 11:39 AM phone call from the physician's nurse which indicated the physician was aware of the resident's trip to the emergency department last night. Informed the physician's nurse the resident was sleeping today; no aggressive behaviors and the nurse indicated the physician said next step was Haldol and call if needed.

2/1/19 at 8:10 PM licensed nurse G received a phone call from staff the resident had shut the room door in staff's face and then the staff heard a thud and found the resident on the floor on

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his/her back. Nurse G and staff were able to assist the resident to get up and the resident ambulated without difficulty. Note: the notes did not include an investigation of the causal factors and the NSA/HCS was not amended with interventions to reduce the risk of further falls.

Note: the nursing notes lacked information about a fall on 2/3/19 as recorded on the shift to shift report sheet.

2/4/19 (no time indicated) licensed nurse/operator C wrote resident now on Haldol and Seroquel due to extremely aggressive behaviors. Resident had hit staff, broke items in the house, went in and out of other resident's rooms and knocked over furniture. With the addition of Haldol, the resident is calmer and resting for longer periods of time and has only shown a small amount of aggression when prompted to use the bathroom. The NSA/HCS lacked an amendment to address the resident's wandering, combative/aggressive behaviors and falling episodes.

Interview on 2/14/19 at 2:30 PM licensed nurse/operator C the admission NSA/HCS failed to address the resident's wandering behavior. He/she confirmed the NSA/HCS plan was not updated when the resident began showing aggressive, combative, violent or resistant behaviors. He/she also confirmed the NSA/HCS plan was not updated with the resident's falls or investigated for causal factors and no interventions developed to reduce the risk of further falls.

Licensed nurse/operator C failed to provide or coordinate the provision of necessary health care services that meet the needs for this resident and were in accordance with the functional capacity

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screening and the negotiated service agreement related to wandering and combative/aggressive behavior and falls.

- Record review conducted on 2/14/19 at 10:25 AM for resident #378 revealed an admission date of 12/05/18 with diagnoses of cardiac stent placement, chronic obstructive pulmonary disease, mild asthma, and recurrent urinary tract infection.

The admission functional capacity screen dated 12/04/18 indicated the resident had short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting, transfers, walking and mobility. He/she was at risk for falls and used a walker.

The negotiated service agreement/health care services (NSA/HCS) dated 12/04/18 directed staff to provide physical assistance of 1 staff for bathing, dressing, toileting, transfers and stand by assist walking with a walker. Under special risk the directions were to provide stand by assist of 1 and walker. The section for siderail use had pre-typed items of 1/4 rail, 1/2 rail, whole rail, cane, attached to frame, attached to bed, purpose, positioning, transferring, ability to locate boundaries of bed and special instructions. All items were blank.

Observation during the initial tour on 2/13/19 at 12:59 PM revealed the resident's bed and an upside-down U-shaped assistive device on the right side of the bed.

Observation on 2/14/19 at 10:15 AM revealed the resident's room door open and the resident sat in the rocking chair watching TV with a 4 wheeled

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walker in front of him/her. The resident's bed no longer had the assistive device in place. The resident said he/she used it to get in/out of bed, to turn over and he/she did not take it off.

Interview on 2/14/19 at 10:15 AM with CMA K revealed he/she did not know why the bed assistive device was no longer on the bed and indicated the device had been on the bed since shortly after the resident admitted.

Interview on 2/14/19 at 10:15 AM with CMA L revealed he/she did not know why the bed assistive device was no longer on the bed, but it was supposed to be.

Interview on 2/14/19 at 10:17 AM with certified nursing assistant F revealed he/she did not know why the bed assistive device was no longer on the bed. Later at 10:22 AM, he/she reported licensed nurse/operator C had removed the device that morning because the record didn't have an order and to ensure the resident would call for help to get up.

Interview on 2/14/19 at 10:40 AM with licensed nurse/operator C confirmed the resident had the bed assistive device, the record failed to have a bed rail assessment and the NSA/HCS lacked the use of the bed assistive device.

Licensed nurse/operator C failed to provide or coordinate the provision of necessary health care services that meet the needs for this resident and were in accordance with the functional capacity screening and the negotiated service agreement related to use of a bed assistive device.

- Record review for resident #410 revealed an admission date of 9/21/18 with diagnoses of

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dementia, pacemaker, atrial fibrillation and history of lung cancer.

Review of the admission functional capacity screening (FCS) dated 9/20/18 revealed the resident had short-term and long-term cognition deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, transfers PRN (as needed) and used a cane. He/she had impaired vision and hearing with impaired decision making but was not marked with falls, unsteadiness.

The nursing assessment dated 9/21/18 indicated the resident walked around the facility using a cane for balance, had an unsteady gait at times and needed standby assistance PRN. The assessment identified the resident with right lower leg edema and history of cellulitis with a plan to monitor. Under the comments licensed nurse/operator C wrote the resident had 2 skin tears on top of each hand ... some old bruising noted on arms and back of hands with thin skin. Updated on 10/12/18 (no time indicated) resident needing assist with most activities of daily living - hand on or at least standby. Resident very pleasant most days and has almost zero short-term memory.

The negotiated service agreement/health care services (NSA/HCS) dated 9/20/18 directed staff to provide assistance with 1 staff for bathing, dressing, transfer assistance PRN and he/she used a cane. Under special risks licensed nurse/operator C marked routine night checks and no other fall risks or management of skin risks.

NSA/HCS amendments as follows:
9/28/18 may have the occasional beer with family

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while watching football at the facility
10/12/18 staff to assist resident with the following needs: shaving, toileting, ambulation and transfers
11/15/18 home health to see resident in facility twice weekly for 9 weeks physical and occupational therapy. Resident to have assistance of walker for ambulation
11/27/18 family wishes to discontinue the home health and therapy services with physician agreement.

Nursing notes dated 9/21/18 at 4:00 PM indicated the resident admitted to the facility with history of dementia. Resident ambulates with a cane and is occasionally unsteady when walking into his/her room.

Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident.

The single sheet undated care plan sheet directed staff to assist the resident with 1 staff for bathing, dressing, toileting, transfers, mobility and used a cane. He/she was at risk for falls but failed to have any directions for interventions to reduce the fall risks. Skin risk was marked as none. The document did not identify the resident's edema or skin condition of cellulitis.

Review of the physician orders revealed on 10/4/18 the physician order for the resident to receive Doxycycline Hyclate 100 milligrams by mouth twice a day with duration of 14 days for cellulitis of right lower leg. He/she also ordered Mupirocin 2% ointment to affected area two times a day with a duration of 14 days for cellulitis of the

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right lower leg. Nursing notes do not include any information about the resident's skin condition and the NSA/HCS failed to be updated to include the condition with interventions to promote healing and to reduce the risk of reoccurrence.

On 10/23/18 the physician ordered Keflex 500 mg by mouth 3 times day with duration of 10 days for right lower leg cellulitis. Licensed nurse/operator C failed to update the NSA/HCS to reflect the resident's condition or interventions to promote healing and reduce the risk of reoccurrence.

Nursing notes documented:

9/21/18 at 4:00 PM resident admitted ... has a history of dementia and was unsure of placement at this time. Resident ambulated with a cane and was occasionally unsteady when walking into his/her room... no sign or symptom of pain or edema ...

10/9/18 at 4:00 PM resident doing very well and adjusted to placement ... started on antibiotic for possible reoccurrence of cellulitis of the right lower extremity, dressing changes done twice daily with Bactroban ointment for 2 weeks.

The next entry was dated 10/13/18 (no time indicated)

10/13/18 (no time indicated) licensed nurse M wrote - this nurse called to assess resident with report of resident fell out of bed. Neurological checks intact, no complaints of tenderness on palpation to extremities times 4, ribs, vertebrae or head. Skin tear noted to left ring finger, cleaned and dressed with triple antibiotic ointment and sterile 2 x 2 dressing then wrapped with gauze wrap. All other skin intact ... resident denied pain

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and family present declined any emergency room care. Th note lacked any investigation information into causal factors of the fall or interventions to reduce the risk of further falls. The NSA/HCS was not updated to reflect the resident's fall or interventions to reduce the risk of further falls.

The next entry was dated 10/23/18 at 10:45 AM

10/23/18 at 10:45 AM resident finished antibiotic last week for right lower extremity (RLE) redness, swelling and possible cellulitis. Today the RLE does not look any better and remained red and swollen. Resident encouraged to elevate the RLE when sitting down and physician's office notified.

The next entry was dated 11/1/18 at 5:00 PM resident doing good. RLE looking better daily and resident encouraged to elevate RLE whenever sitting down. He/she ambulates with a cane and assistance with assistance for ADLs all the time now ...

11/15/18 at 4:30 PM resident returns from a brief hospital stay ... back to baseline.

1/07/19 at 6:00 PM ... resident walks with a walker and assistance ... resident to use call button for assistance.

1/16/19 (no time indicated) resident had some RLE redness and swelling with some scratches and picture sent to the resident's physician with order to start Keflex times 2 weeks. The RLE was cleaned and encouraged the resident to keep it elevated. The NSA/HCS remained without an update of the resident's chronic condition of cellulitis RLE and interventions to promote healing and reduce the risk of reoccurrence.

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S5155	Continued From page 46 The next note and last entry for the record - 1/21/19 (no time indicated) RLE looks better today, less redness and swelling. resident encouraged to continue to elevate leg and not scratch. Review of the shift to shift report sheets revealed the following notations: On 1/27/19 the resident fell on the floor in front of chair with no injuries. The resident's medical record lacked any evidence of this fall, investigation into causal factors or interventions to reduce the risk of further falls. On 2/4/19 keep an eye on bottom, leg for open (the notation was difficult to read) Observation on 2/14/19 at 10:00 AM revealed certified nursing assistant (CNA) L assisted the resident to stand from a chair at the dining table, walk with a front wheeled walker giving standby assist, verbal cues and directions. CNA L directed the resident into the bathroom. Observation revealed the resident had 2 pinpoint white tissue spots on bilateral buttocks that lined up with each other, just below the one on the right buttock was a different shade of pink scar tissue in a circular pattern. CNA L reported the areas where old. Once the resident was seated on the toilet CNA L lowered the resident's pants down to the ankles. Observation revealed the right leg a deep red color, with small faint scabbed areas, no weeping and slight edema. Interview with CNA L at that time revealed he/she did not know of any interventions to help the resident's legs other than compression stockings but he/she did not know if the physician ordered them. When asked about fall prevention he/she reported just anticipating resident's needs and giving standby assistance.	S5155		

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Interview with licensed nurse/operator C on 2/14/19 at 2:30 PM confirmed the resident had fallen on 1/27/19 without any documentation in the medical record or evidence of a nurse assessment. He/she confirmed the NSA/HCS failed to identify the resident's fall risk and develop interventions to reduce the further risk of falls. He/she confirmed the NSA/HCS was not updated after the fall on 1/27/19 with interventions to reduce the risk of further falls. He/she confirmed the resident had a chronic condition of RLE cellulitis and the NSA/HCS lacked any information about the condition, measures to promote healing or interventions to reduce the risk of reoccurrence.

Licensed nurse/operator C failed to provide or coordinate the provision of necessary health care services that meet the needs for this resident and were in accordance with the functional capacity screening and the negotiated service agreement related to fall risk, skin risks and chronic condition of RLE cellulitis.

- Record review for resident #414 revealed an admission date of 10/29/17 with diagnoses of anxiety, depression, hypertension and chronic pain.

The annual functional capacity screen dated 10/25/18 revealed the resident had short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she required physical assistance with bathing, was at risk for falls or had an unsteady gait and used a walker.

The negotiated service agreement/health care services (NSA/HCS) dated 10/25/18 indicated the resident received home health nursing services

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S5155	Continued From page 48 for management and changing of a supra pubic catheter. He/she needed stand by assistance with transfers and used a walker. He/she needed physical assistance of 1 staff with bathing twice awake. The NSA/HCS plan was amended on 2/9/19 for resident needing assistance with transfers, toileting, showers and ADLs (activities of daily living) at this time due to ankle pain. The NSA/HCS was not updated to include the resident's fall or interventions to reduce the risk for further falls. Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident. The single sheet undated care plan sheet directed staff to assist the resident with bathing 2 times a week and provide stand by assistance with transfers PRN (as needed) with mobility by walker and stand by assist. The care plan sheet was updated on 2/9/19 for staff to help resident with ADLs (activities of daily living), transfers and toileting. The undated care plan sheet did not include the resident's fall or interventions to reduce the risk of further falls. Review of the nursing notes revealed an entry on 2/10/19 (no time indicated) nurse was informed the resident suffered a fall which resulted in a fracture to the right ankle and complaints of pain. Tramadol ordered ... educated resident and staff on using ice for 15-20 minutes intervals to relieve pain and rest. 2/11/19 (no time indicated) resident doing well this morning with tramadol PRN for pain control. Resident will follow up with orthopedic surgeon at a later date.	S5155		

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S5155	Continued From page 49 Review of a staff communication book revealed an entry dated 2/10/19 resident #414 fell before/after the shower on 2/9/19 and the family member was called instead of notifying a nurse on staff. The resident fractured his/her ankle - he/she needs to use his/her scooter to get back/forth but wants to use the chair. Interview on 2/14/19 at 11:55 AM with licensed nurse/operator C confirmed the record lacked X-ray results or any evidence of the injury. He/she reported the resident did not actually fall but twisted his/her ankle getting out of the shower. A request to review the investigation of the incident revealed he/she was not aware of an investigation but would check. He/she did not know if statements were obtained from the staff about the injury or cares with the bathing. He/she did not at this time know which staff provided assistance with the shower on 2/9/19. At 12:49 PM, licensed nurse/operator C confirmed nothing was documented about the incident and there should have been. He/she confirmed the NSA/HCS was not updated to indicate the resident had a fall or interventions to reduce the risk of further falls. Review of X-ray results licensed nurse/operator C obtained on 2/14/19 at 1:11 PM revealed the right ankle had soft tissue swelling at the ankle, osseous fragmentation to the medial malleolus with relatively acute-appearance. Review of the facility's resident fall prevention procedures and policy dated 10/1/18 revealed a list of factors and possible interventions but failed to include procedures to follow when a fall occurs. Licensed nurse/operator C failed to investigate for casual factors of a reported fall or other causal	S5155		

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S5155	Continued From page 50 factors for a fractured ankle and failed to update the NSA/HCS with the fall or injury cause and interventions to reduce the risk of further falls or injuries.	S5155		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (f) (11) The facility reported a census of 7 residents. The sample included 3 residents and 2 for focused review of safety. Based on observation, interview and record review the operator failed to ensure a licensed nurse documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action for 4 of 5 sampled residents (#312, #364, #410 and #414). Findings included: - Observation during the initial tour on 2/13/19 at 12:41 PM of resident #312's room revealed the resident's room had some of the resident's belongings piled on the bed and personal belongings remained on the wall. Certified nursing assistant F reported the resident had passed away that morning.	S5251		

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S5251	Continued From page 51 Record review revealed the resident admitted to the facility on 1/14/19 with diagnoses of Alzheimer's, depression and gout. The admission functional capacity screen (FCS) dated 1/11/19 identified the resident with short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, dressing, toileting and eating and was independent with transfer, walking and mobility. He/she had impaired communication rarely or never understood others verbal information but was sometimes understood with self-expression. Under current or recent problems and risks the resident had impaired vision, impaired decision making, socially inappropriate/disruptive behavior with possibility of agitation. The negotiated service agreement/health care services (NSA/HCS) dated 1/11/19 indicated the facility provided assistance of 1 staff with bathing, dressing, oral care and toileting. The resident independently transferred and ambulated. Under special risks he/she needed routine night checks. Under management of behavioral symptoms licensed nurse/operator C marked the preprinted interventions of redirection, distraction or music therapy, management of elopement risk/monitor doors/exits and orientate to person, place and times as needed. Review of the nursing assessment dated 1/14/19 indicated the resident needed assistance with activities of daily living (ADLs) but independent with walking. Under the comments - resident has severe dementia/Alzheimer's, unable to put complete sentences together or comprehend simple commands, talks gibberish most of the time and wanders around.	S5251		

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S5251	Continued From page 52 On 2/13/19 at 12:57 PM licensed nurse/operator C reported they had an aggressive resident who was trying to strike certified medication aide (CMA) B when certified nursing assistant (CAN) A intervened and the resident had a fall. He/she indicated the facility had video footage of the incident. Review of the video footage with licensed nurse/operator C on 2/13/19 at 1:52 PM revealed a recording of an incident on 1/29/19 beginning at 6:18 PM with resident #312, CMA B and CNA A. The video showed CNA A grabbed the resident's right arm with both his/her hands and pulled forcefully enough to cause the resident to circle/stumble around to the right. CNA A maintained both hands on the resident's right arm and pulled in a continuous back circle motion towards the dining table. The resident struck the dining room table with enough force for the table to move at least 6 inches. CNA A continued to grasp the resident's right arm with both hands as the resident had a downward trajectory where he/she also collided with a chair knocking it over and landed face forward on the floor. Review of the daily shift to shift report sheets between 1/14/19 and 2/13/19 revealed the following documentation: 1/20/19 - resident urinated in trash can, was combative, tearing up his/her room and slept in recliner for about 4 hours 1/23/19 - up and around all day, broke a doorknob and threw lots of punches Note: Shift to shift report sheet updated next to resident #312's name to state: wanders, elopement risk and watch for agitation 1/26/19 - resident gave him/herself a skin tear on his/her left hand, very agitated all day and broke	S5251		

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S5251	Continued From page 53 closet doors. 1/27/19 - 3rd person to be with resident and he/she must be kept out of other rooms. Very violent and combative with family member of resident 1/29/19 - dangerously aggressive - fell because he/she was trying to strike staff and had to be pulled away. 2/01/19 - resident fell twice (at 8:40 PM and 10:51 PM) 2/03/19 - resident was put in a chair and now laying on the floor. 2/04/19 - Hold Haldol, yelling in a lot of pain and slept in living room 2/05/19 - on floor a lot then in his/her chair etc. Review of the comments book between 1/14/19 and 2/5/19 revealed: 1 undated entry that reflected resident was resistant to changing soiled clothes, urinated on the floor and talked to self. 1/18/19 7:00 PM wandering and rearranging everything, sitting out in TV room or dining room with failed attempts to get him/her in bed. At 12:45 AM after he/she dump salt everywhere the resident finally got in bed but would still not change his/her clothes. 1/29/19 without a time - moved dresser out of resident's room as he/she had pulled the dresser over again. He/she broke the TV and family took it home. 2/5/19 without a time - resident was in the living area when staff arrived and was assisted with medications. The resident could not use his/her feet, was dead weight and the 2 staff could not get the resident into the wheelchair. Staff made the resident comfortable and notified the nurse. The resident seemed to be in a lot of pain on the left side, hurts when moved and yelled out.	S5251		

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Nurses Notes documented:

Review of the resident's record revealed the notes go from 1/14/19 with next note 1/30/18 (typo noted) had no documentation in the nursing notes about combative behavior on 1/20/19, breaking items and throwing punches on 1/23/19, the skin tear noted on 1/26/19, violent or combative behavior with the family member of the resident on 1/27/19, nor the incident with Certified Staff A and B on 1/29/19.

On 1/30/19 at 10:37 PM by licensed nurse E, "notified by staff patient was found on the floor in room. On arrival staff had placed patient back in bed. Patient has diminished breath sound on right, patient winces when right ribs palpated. Notified family member who stated patient seemed like he/she had pain in right ribs this morning when he/she saw the resident. Licensed nurse E called emergency medical services (EMS) for transport to emergency room (ER)."

The record lacked any reports, labs or X-rays performed at the hospital on 1/30/19.

Note: record lacks documentation of return to the facility from the emergency room with the next note dated 1/31/19 at 11:39 AM.

2/1/19 at 8:10 PM licensed nurse G received a phone call from staff the resident had shut the room door in staff's face and then the staff heard a thud and found the resident on the floor on his/her back. Nurse G and staff were able to assist the resident to get up and the resident ambulated without difficulty.

The notes lacked information about the fall at 10:51 PM mentioned on the shift to shift report

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sheet for 2/1/19. The notes also lacked information about the fall noted on the shift to shift report sheet on 2/3/19.

2/4/19 (no time indicated) licensed nurse/operator C wrote resident now on Haldol and Seroquel due to extremely aggressive behaviors. Resident had hit staff, broke items in the house, went in and out of other resident's rooms and knocked over furniture. With the addition of Haldol, the resident is calmer and resting for longer periods of time and has only shown a small amount of aggression when prompted to use the bathroom.

The notes lacked any information about the resident yelling in pain as recorded on the 2/04/19 shift to shift report sheet.

2/5/19 (no time indicated) licensed nurse/operator C wrote resident more sleepy today and required assistance with all transfers, had to be prompted to eat and drink. Morning Haldol held, resident assisted with meals and going to the bathroom rest of the day.

The notes lacked any information of a nurse assessment regarding the documentation of pain in the staff communication book on 2/05/19.

On 2/14/19 the surveyor requested licensed nurse/operator C obtain the hospital record and X-ray report for the visit on 1/30/19. The X-ray report of 1/30/19 revealed a questionable minimally displaced posterior right 9th rib fracture with a new coarse right basilar reticulation, suspicious of infection or aspiration or contusion could appear similar.

Interview on 2/13/19 at 2:40 PM with licensed nurse/operator C confirmed the resident's

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medical record failed to have documentation about incident, illness, injuries as discovered in the shift to shift report sheets, staff communication book and surveillance video recording. He/she confirmed the resident's record also lacked documentation about actions taken and results of actions taken as outlined above.

Licensed nurse/operator C failed to ensure a licensed nurse documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action for this resident.

- Record review for resident #364 revealed an admission date of 9/12/18 with diagnoses of Alzheimer's, normal pressure shunt placement, hypothyroidism and high cholesterol.

Review of the admission functional capacity screening dated 9/12/18 revealed the resident had short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she required physical assistance with bathing, dressing, toileting, transfers, ambulation and mobility.

The negotiated service agreement/health care services (NSA/HCS) dated 9/12/18 indicated facility staff would provide 2 staff assistance with bathing, dressing, toileting, transfers and using the walker only to stand. The section for management of skin risk contained a typed listing of possible interventions with none marked.

Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the

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resident.

The single sheet undated care plan sheet without any dated changes directed staff to provide assistance of 2 staff for bathing, dressing, toileting, transfers and to use a body alarm at bedtime continuous. He/she was marked with skin risk and no interventions to reduce those risks.

On 2/13/19 review of the staff communication book revealed an entry dated 1/18/19 about the resident assisted to bed and still has a blood spot on the left heel - pillow was put under the foot. Note: This is not reflected in the nursing notes or any actions taken.

Review of the shift to shift report sheets revealed on 1/14/19 the resident received a shower and no documentation of a skin integrity alteration. On 1/15/19 washed resident's linen and no indication of a skin alteration. On 1/18/19 kept foot completely off the bed.

Nursing notes documented between 9/12/18 (admission) to 2/02/19 (last entry):

None of the nursing notes between 1/11/19 and last entry dated 2/2/19 or any documents within the resident's medical records reflected the resident had a pressure ulcer on the left heel, a nurse assessment, actions taken or ongoing monitoring for results of actions.

1/27/19 at 11:05 PM resident resting in a chair with cool rag to forehead, face red-flushed, skin warm to touch, vital signs ... temp 103.1 degrees Fahrenheit, breathing labored at 26 respirations per minute, fine crackles to bilateral lower lobes with inspiratory and expiratory wheezes and

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resident mildly lethargic. The durable power of attorney wanted the resident to be assessed in the emergency department (ED) but did not want him/her admitted to the hospital. emergency medical services were called for transport to ED. Will continue to monitor and assess as needed.

The next nursing note was dated 2/1/19 at 6:20 PM.

Licensed nurse/operator C provided a copy of hospital discharge notes dated 1/30/19. The nursing notes lacked documentation of admission to the hospital or the discharge and condition of the resident upon readmission.

On 2/14/19 at 9:25 AM the resident declined to allow the surveyor to observe routine incontinent care and repositioning. While the surveyor spoke with the resident certified medication aide (CMA) L pulled the covers off the resident's feet. Observation revealed the left heel had a covering, was in a foam protector and elevated on a pillow.

Interview on 2/14/19 at 2:30 PM with licensed nurse/operator C confirmed the resident still had an area on his/her left heel and confirmed the record lacked documentation of the pressure ulcer, actions taken and results of actions. He/she confirmed the record lacked information about the hospital admission and his/her return to the facility.

Licensed nurse/operator C failed to ensure a licensed nurse documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action for this resident.

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S5251	Continued From page 59 - Record review for resident #410 revealed an admission date of 9/21/18 with diagnoses of dementia, pacemaker, atrial fibrillation and history of lung cancer. Review of the admission functional capacity screening (FCS) dated 9/20/18 revealed the resident had short-term and long-term cognition deficit, memory recall deficit and impaired decision making. He/she needed physical assistance with bathing, transfers PRN (as needed) and used a cane. He/she had impaired vision and hearing with impaired decision making. The nursing assessment dated 9/21/18 indicated the resident walked around the facility using a cane for balance, had an unsteady gait at times and needed standby assistance PRN. The assessment identified the resident with right lower leg edema and history of cellulitis with a plan to monitor. The negotiated service agreement/health care services (NSA/HCS) dated 9/20/18 directed staff to provide assistance with 1 staff for bathing, dressing, transfer assistance PRN and he/she used a cane. Under special risks licensed nurse/operator C marked routine night checks and no other fall risks or management of skin risks. NSA/HCS amendments as follows: 9/28/18 may have the occasional beer with family while watching football at the facility 10/12/18 staff to assist resident with the following needs: shaving, toileting, ambulation and transfers 11/15/18 home health to see resident in facility twice weekly for 9 weeks physical and occupational therapy. Resident to have	S5251		

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assistance of walker for ambulation
11/27/18 family wishes to discontinue the home health and therapy services with physician agreement.

Licensed nurse/operator C on 2/13/19 indicated the health service plan was a single page document in the vital signs book which staff referred to for directions on how to care for the resident.

The single sheet undated care plan sheet directed staff to assist the resident with 1 staff for bathing, dressing, toileting, transfers, mobility and used a cane. He/she was at risk for falls but failed to have any directions for interventions to reduce the fall risks. Skin risk was marked as none. The document did not identify the resident's edema or skin condition of cellulitis.

Review of the physician orders revealed on 10/4/18 the physician order for the resident to receive Doxycycline Hyclate 100 milligrams by mouth twice a day with duration of 14 days for cellulitis of right lower leg. He/she also ordered Mupirocin 2% ointment to affected area two times a day with a duration of 14 days for cellulitis of the right lower leg. Nursing notes do not include any information about the resident's cellulitis of the right lower leg until 10/9/18.

On 10/23/18 the physician ordered Keflex 500 mg by mouth 3 times day with duration of 10 days for right lower leg cellulitis.

Nursing notes documented:

9/21/18 at 4:00 PM resident admitted ... has a history of dementia and was unsure of placement at this time. Resident ambulated with a cane and

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S5251	Continued From page 61 was occasionally unsteady when walking into his/her room... no sign or symptom of pain or edema ... 10/9/18 at 4:00 PM resident doing very well and adjusted to placement ... started on antibiotic for possible reoccurrence of cellulitis of the right lower extremity, dressing changes done twice daily with Bactroban ointment for 2 weeks. The next entry was dated 10/13/18 (no time indicated) 10/13/18 (no time indicated) licensed nurse M wrote - this nurse called to assess resident with report of resident fell out of bed. Neurological checks intact, no complaints of tenderness on palpation to extremities times 4, ribs, vertebrae or head. Skin tear noted to left ring finger, cleaned and dressed with triple antibiotic ointment and sterile 2 x 2 dressing then wrapped with gauze wrap. All other skin intact ... resident denied pain and family present declined any emergency room care. The next entry was dated 10/23/18 at 10:45 AM 10/23/18 at 10:45 AM resident finished antibiotic last week for right lower extremity (RLE) redness, swelling and possible cellulitis. Today the RLE does not look any better and remained red and swollen. Resident encouraged to elevate the RLE when sitting down and physician's office notified. The next entry was dated 11/1/18 at 5:00 PM resident doing good. RLE looking better daily and resident encouraged to elevate RLE whenever sitting down. He/she ambulates with a cane and assistance with assistance for ADLs all the time now ...	S5251		

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S5251	Continued From page 62 11/11/18 at 1:35 PM licensed nurse G documented he/she received a phone call from staff voicing concern for the resident being very weak, barely keep his/her eyes open and blood in the stool. ... B/P 90/60 ... resident reports feeling more tired than usual. Resident's skin pale and cool, heart rate tachy with regular rhythm, lung sounds clear bilateral ... nurse discussed options with family and agreed resident needed to be evaluated at the emergency room. ... Emergency medical services (EMS) arrived and resident transferred to the EMS gurney. The next note was 11/15/18 at 4:30 PM. 11/15/18 at 4:30 PM resident returns from a brief hospital stay ... back to baseline. Subsequent notes dated 12/4/18 at 5:00 PM, 1/07/19 at 6:00 PM had no mention of the resident's RLE condition. 1/16/19 (no time indicated) resident had some RLE redness and swelling with some scratches and picture sent to the resident's physician with order to start Keflex times 2 weeks. The RLE was cleaned and encouraged the resident to keep it elevated. The next note and last entry for the record - 1/21/19 (no time indicated) RLE looks better today, less redness and swelling. resident encouraged to continue to elevate leg and not scratch. Review of the shift to shift report sheets revealed the following notations: On 1/27/19 the resident fell on the floor in front of chair with no injuries. Note: nursing notes ended	S5251		

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on 1/21/19 and did not reflect this fall or a nurse assessment for injuries or any actions taken. On 2/4/19 "keep an eye on bottom leg for open" (the notation was difficult to read)

Observation on 2/14/19 at 10:00 AM revealed certified nursing assistant (CNA) L assisted the resident to the bathroom. Observation revealed the right lower leg was a deep red color, with small faint scabbed areas, no weeping and slight edema.

Interview with licensed nurse/operator C on 2/14/19 at 2:30 PM confirmed the resident had fallen on 1/27/19 without any documentation in the medical record or evidence of a nurse assessment. He/she confirmed the resident had a chronic condition of RLE cellulitis and the nursing notes did not reflect professional standards of monitoring the condition while under treatment and routine evaluation. He/she confirmed the record lacked information about being admitted to the hospital on 11/11/18.

Licensed nurse/operator C failed to ensure a licensed nurse documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action for this resident.

- Record review for resident #414 revealed an admission date of 10/29/17 with diagnoses of anxiety, depression, hypertension and chronic pain.

The annual functional capacity screen dated 10/25/18 revealed the resident had short-term and long-term memory deficit, memory recall deficit and impaired decision making. He/she

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required physical assistance with bathing, was at risk for falls or had an unsteady gait and used a walker.

The negotiated service agreement/health care services (NSA/HCS) dated 10/25/18 indicated the resident received home health nursing services for management and changing of a supra pubic catheter. He/she needed stand by assistance with transfers and used a walker. He/she needed physical assistance of 1 staff with bathing twice awake. The NSA/HCS plan was amended on 2/9/19 for resident needing assistance with transfers, toileting, showers and ADLs (activities of daily living) at this time due to ankle pain.

Review of the nursing notes revealed an entry on 2/10/19 (no time indicated) nurse was informed the resident suffered a fall which resulted in a fracture to the right ankle and complaints of pain. Tramadol ordered ... educated resident and staff on using ice for 15-20 minutes intervals to relieve pain and rest. 2/11/19 (no time indicated) resident doing well this morning with tramadol PRN for pain control. Resident will follow up with orthopedic surgeon at a later date.

Review of a staff communication book revealed an entry dated 2/10/19 resident #414 fell before/after the shower on 2/9/19 and the family member was called instead of notifying a nurse on staff. The resident fractured his/her ankle - he/she needs to use his/her scooter to get back/forth but wants to use the chair.

Interview on 2/14/19 at 11:55 AM with licensed nurse/operator C confirmed the record lacked X-ray results.

Review of X-ray results dated 2/9/19 which

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S5251	Continued From page 65 licensed nurse/operator C obtained on 2/14/19 at 1:11 PM revealed the right ankle had soft tissue swelling at the ankle, osseous fragmentation to the medial malleolus with relatively acute-appearance. Licensed nurse/operator C failed to ensure a licensed nurse documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action for this resident.	S5251		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d)	S5300		

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The facility reported a census of 7 residents. The sample included 3 residents and 2 with a focused review for safety. Based on record review and interview licensed nurse/operator C failed to ensure 1 of 3 sampled residents (#364) received medications administered by facility staff in accordance with a medical care provider's written order and professional standards of practice.

Findings included:

- Record review for resident #364 revealed an admission date of 9/12/18 with diagnoses of Alzheimer's, normal pressure shunt placement, hypothyroidism and high cholesterol.

Review of the admission functional capacity screening dated 9/12/18 revealed the resident had short-term and long-term memory deficit, memory recall deficit and impaired decision making. The resident was unable to manage his/her own medications and treatments.

The negotiated service agreement/health care services (NSA/HCS) dated 9/12/18 indicated facility staff would provide medication management. The NSA/HCS plan was amended on 2/1/19 to include resident on Hospice care, in a hospital bed, staff to use a lift with 2 assist to get resident out of the bed PRN (as needed). Hospital bed with bedrails.

Note record review conducted on 2/14/19 at 8:55 AM

Review of the physician's orders revealed admission orders dated 9/12/18 by the resident's physician as follows:
Cholestyramine packet mix contents of 1 packet with 4-6 ounces of liquid and drink every day for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B029001	A. BUILDING: _____ B. WING _____	02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RL DODGE CITY I, LLC	2800 6TH STREET DODGE CITY, KS 67801

(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
S5300	Continued From page 67	S5300		

high cholesterol
Alprazolam 0.5 milligrams (mg) take 1 tablet by mouth every HS (bedtime) for anxiety
Trazodone 50 mg take 1 tablet by mouth every HS for depression
Escitalopram 20 mg take 1 tablet by mouth every day for depression
Levothyroxine 25 micrograms by mouth every day for hypothyroidism
Acetaminophen 325 mg take 2 tablets by mouth every 6 hours for pain
Risperidone 0.5 mg tablet take 1 by mouth every morning and 2 tablets by mouth every HS for irritability
Miralax 17 grams daily for constipation

Review of the January 2019 medication administration record (MAR) revealed the resident received the above prescribed medications as ordered 1/01, 2019 through 1/27/19. The record indicated on 1/28/19 the resident was on a leave of absence. On January 30, 2019 the following medication changes were implemented:
Risperidone 0.5 mg changed to 1 tablet by mouth daily for irritability
Acetaminophen 325 mg 2 tablets from every 6 hours to every 6 hours PRN (as needed)
Addition of Bisacodyl suppository 10 mg rectally PRN constipation
Change from Alprazolam to Lorazepam 0.5 mg sublingual (SL) every 6 hours PRN anxiety
Addition of Morphine sulfate 20 mg SL every hour PRN pain on scale of 5-10
Addition of Ondansetron 4 mg by mouth every 4 hours PRN

Review of the nursing notes on 1/27/19 at 11:05 AM the resident's rested in a chair with a cool rag to forehead, his/her face red-flushed and skin

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S5300	Continued From page 68	S5300		

warm to touch. Vital signs temperature of 103.1 degrees Fahrenheit ... breathing labored with respirations 26 per minute with fine crackles to bilateral lower lobes and inspiratory/expiratory wheezing. Resident mildly lethargic, family member present and requested resident be assessed in the emergency department (ED) but does not want him/her admitted to the hospital. Emergency medical services called to transport.

The record lacked an outcome of the ED visit with the next note dated 2/1/19 at 6:20 PM.

Interview on 2/14/19 at 9:50 AM with licensed nurse/operator C confirmed the record did not contain physician orders for the above changes. Later that day at approximately 10:30 AM, he/she provided discharge orders from the hospital.

The interagency transfer summary form was not signed by a physician and for medications read to see MAR. The document titled discharge medication list dated 1/30/19 and timed at 11:01 AM listed the name of the hospital attending physician J and were unsigned. These orders reflected the above changes.

The record lacked an order from the resident's physician to use the orders as written from the hospital discharge.

The record included a phone order written by licensed nurse/operator C dated 2/4/19 to discontinue cholestyramine, levothyroxine and escitalopram resident on Hospice care.

Review on the February 2019 MAR revealed facility staff administered the Risperidone 0.5 mg once a day 2/1/19 thru 2/13/19. The Alprazolam ordered for every HS on 9/12/18 was

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S5300	Continued From page 69 discontinued and the resident had not received any PRN doses of the Lorazepam. Interview on 2/14/19 at 11:55 AM with licensed nurse/operator C confirmed the record lacked an order from the resident's physician for the medication changes on 1/30/19 and confirmed the MAR reflected the medication changes with staff administering the Risperidone only once a day and no Alprazolam. Licensed nurse/operator C failed to ensure this resident received medications administered by facility staff in accordance with a medical care provider's written order and professional standards of practice.	S5300		