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	B073001	A. BUILDING: _____ B. WING _____	11/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LARNED HOME PLUS	710 W 9TH STREET LARNED, KS 67550

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S 000	INITIAL COMMENTS The following citations represent the findings of the abbreviated survey for complaint #130975 of the above named facility conducted on 11/20/18, 11/21/18 and 11/26/18.	S 000		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201 (c) (2) The facility reported a census of 10 residents. The sample included 3 residents. Based on record review and interview the administrator failed to ensure designated staff conducted a functional capacity screening following a significant change in condition for 1 of 3 sampled residents (#202). Findings included: - Record review for resident #202 revealed an admission date of 5/7/18 with diagnosis of Alzheimer's disease and hypertension. The admission functional capacity screen (FCS) dated 5/7/18 indicated the resident had short and	S5085		

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

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S5085	Continued From page 1	S5085		

long-term memory impairment, impaired memory recall and decision making. He/she needed physical assistance with bathing and dressing and supervision with transfers and walking. The record lacked a FCS following a fall on 5/12/18 which resulted in a fractured right arm and left lower leg that altered the resident's functional mobilities. He/she required a knee immobilizer on the left knee, a sling on the right arm, an order to be non-weight bearing and needed a total body lift to transfer.

Review of the resident's progress notes revealed on 5/12/18 at 3:00 AM staff found the resident on the floor in his/her room. The resident had no complaints of pain at the time and staff assisted him/her to bed. On 5/12/18 at 11:00 AM licensed nurse A received notification that the resident would not get out of bed, complaints of left leg and hip pain with no rotation, deformity or bruising noted. Nurse A notified the physician and the resident was transported to the emergency room (ER) by emergency medical services (EMS).

The post ER visit instructions dated 5/12/18 indicated the resident had a fractured right arm and left leg just below the knee. The instructions directed staff to keep the sling on the resident's right arm, keep knee immobilizer on the left leg, non-weight bearing, fall precautions and pain medications as needed.

On 5/15/18 licensed nurse B sent a fax to a durable medical equipment company related to the physician's order for a wheelchair with left leg support due to her fractures and non-weight bearing status.

Interview on 11/20/18 at 3:15 PM with administrator H confirmed the licensed nurse did

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S5085	Continued From page 2 not complete a FCS following the fall on 5/12/18 and the resident's change in functional abilities, need for assistive devices, non-weight bearing, knee immobilizer and arm sling. The administrator failed to ensure designated staff conducted a functional capacity screening following a significant change in condition	S5085		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202 (a)(1)(2)(3) The facility reported a census of 10 residents. The sampled included 3 residents. Based on record review and interview the administrator failed to ensure the resident's negotiated service agreement contained the description of services	S5105		

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S5105	Continued From page 3	S5105		

the resident would receive, identification of the provider of each service and the party responsible for payment of the services for 1 of 3 residents (#202).

Findings included:

- Record review for resident #202 revealed an admission date of 5/7/18 with diagnosis of Alzheimer's disease and hypertension.

The admission functional capacity screen (FCS) dated 5/7/18 indicated the resident needed physical assistance with bathing and dressing and supervision with transfers and walking. The FCS identified the resident with short and long-term memory impairment, impaired memory recall and decision making.

The negotiated service agreement (NSA)/health service plan (HSP) dated 5/7/18 indicated the resident could toilet independently and required supervision with transfers, walking and mobility with use of a walker. The NSA/HSP indicated the resident needed supervision due to cognitive impairment and socially inappropriate behaviors and can be disruptive at times. The attached Fall Intervention Plan with a start date of 5/7/18 included directions to staff to assist the resident with learning the use of a walker. On 5/12/18 licensed nurse A updated the plan with removal of the wheeled walker in response to a fall while using the walker. No other updates were made to the NSA/HSP regarding change in care needs related to the fall.

Review of the record revealed on 5/31/18 the resident was evaluated by physical therapy (PT) for services related to right knee pain, decreased range of motion and difficulty with ambulation. At

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S5105	Continued From page 4 some point the resident began PT services, however the record did not clearly reflect a start date. PT notes dated 6/12/18 through 6/25/18 reflected the resident's participation in PT. The NSA/HSP lacked a revision or amendment for the outside provider of physical therapy services, the name of the provider or the person responsible for payment of the services. Interview on 11/20/18 at 3:15 PM with administrator H confirmed the NSA/HSP lacked a revision or amendment regarding starting of physical therapy services. The administrator failed to ensure the resident's negotiated service agreement contained the description of services the resident would receive, identification of the provider of each service and the party responsible for payment of the services.	S5105		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 10 residents.	S5155		

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S5155	Continued From page 5 The sample included 3 residents. Based on observation, interview and record review for 2 of 3 residents sampled (#202 and #191) the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement regarding reduction of fall risks. Findings included: - Record review for resident #202 revealed an admission date of 5/7/18 with diagnosis of Alzheimer's disease and hypertension. The significant change functional capacity screen (FCS) dated 7/3/18 indicated the resident required physical assistance with toileting, transfers and was unable to walk. The admission FCS dated 5/7/18 indicated the resident needed physical assistance with bathing and dressing and supervision with transfers and walking. Both FCS identified the resident with short and long-term memory impairment, impaired memory recall and decision making. The negotiated service agreement (NSA)/health service plan (HSP) dated 5/7/18 indicated the resident could toilet independently and required supervision with transfers, walking and mobility with use of a walker. The NSA/HSP indicated the resident needed supervision due to cognitive impairment and socially inappropriate behaviors and can be disruptive at times. The attached Fall Intervention Plan with a start date of 5/7/18 included directions to staff to assist the resident with learning the use of a walker. On 5/12/18 licensed nurse A updated the plan with removal of	S5155		

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the wheeled walker in response to a fall while using the walker. No other updates were made to the NSA/HSP regarding change in care needs related to the fall.

Review of the resident's progress notes revealed on 5/12/18 at 3:00 AM staff found the resident on the floor in his/her room and could not tell staff what happened. The resident had no complaints of pain at the time and staff assisted him/her to bed. 5/12/18 at 11:00 AM licensed nurse A received notification that the resident would not get out of bed, complaints of left leg and hip pain with no rotation, deformity or bruising noted. Nurse A notified the physician and the resident was transported to the emergency room (ER) by emergency medical services (EMS). The record lacked a entry about the resident's return to facility, the discharge from ER instructions and the change in the resident's care needs.

The post ER visit instructions dated 5/12/18 indicated the resident had a fractured right arm and left leg just below the knee. The instructions directed staff to keep the sling on the resident's right arm, keep knee immobilizer on the left leg, non-weight bearing, fall precautions and pain medications as needed.

On 5/15/18 licensed nurse B sent a fax to a durable medical equipment company related to the physician's order for a wheelchair with left leg support due to her fractures and non-weight bearing status. The NSA/HSP did not reflect this change in the resident's status.

On 5/31/18 the resident was evaluated by physical therapy (PT) for services related to right knee pain, decreased range of motion and difficulty with ambulation. At some point the

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resident began PT services, however the record did not clearly reflect a start date. PT notes dated 6/12/18 through 6/25/18 reflect the resident's participation in PT. The notes reflect the resident had difficulty following directions due to decreased cognition. The notes on 6/18/18 indicated the resident needed to be transferred by a total body lift due to non-weight bearing left lower extremity and right upper extremity. The PT note dated 6/25/18 indicated the resident's left knee immobilizer was repositioned for appropriate fit. He/she was completely dependent with bed mobility and transfers with a total body lift. The NSA/HSP did not reflect this change in the resident's status.

Physician's order on 6/25/18 upgraded the resident to a 30% weight bearing status on the left leg. The NSA/HSP did not reflect this change or provide the staff with directions for care.

Review of the resident's progress notes revealed an entry dated 6/27/18 at 9:30 AM by licensed nurse B revealed he/she was notified at 5:35 AM of the resident falling out of the recliner. Staff had not put the resident in bed and reported as the resident request. The assessed the resident and noted no injuries.

Review of the facility's incident report revealed on 6/27/18 at 5:10 AM certified nursing assistant C went to check on resident and found the resident on the floor leaning against the recliner. He/she notified the certified medication aide (CMA) and nurse on-call. He/she wrote the resident slid out of the recliner. Licensed nurse B wrote staff had allowed the resident to sleep in the recliner. The NSA/HSP does not reflect the recliner as the resident's preferred sleeping surface. The investigation did not indicate where the feet were

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in the upright position on not. The resident wore a left leg immobilizer and would need to have the feet elevated.

Observation on 11/20/18 at 2:03 PM revealed the resident's recliner had a hand operated lever required to put the feet up and down. CMA D approximate size of the resident sat in the recliner and with significant force elevated the feet which resulted in a rapid jerky reclining position. He/she demonstrated the feet of the recliner could not be put down with just the use of his/her feet and needed activation of the hand lever which again made a rapid jerky movement forward.

Interview on 11/20/18 at 2:00 PM with CMA D, CMA E revealed the resident had always required staff to operate the recliner form him/her.

The fall intervention plan was updated on 6/27/18 with staff educated to not put the resident in his/her recliner after 6:00 PM so he/she does not think the was an option for bed to prevent falls.

On 7/3/18 licensed nurse F developed a new NSA/HSP which indicated the resident needed physical assistance with bathing, personal hygiene and totally dependent for dressing, toileting, transfer and mobility. The section for transfers direct the resident used a lift for transfer due to recent fractures and restricted weight-bearing status. The section on mobility directed the resident required a wheelchair for mobility which staff propelled, see fall interventions and the resident required physical assistance to exit the facility in the event of an emergency. The fall intervention plan included to continue care plan updated 7/3/18. The NSA/HSP did not indicate if the resident still wore the left leg immobilizer or right arm sling. Review of the

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physician's orders revealed no orders to stop using the immobilizer or sling.

Review of the resident's progress notes revealed an entry dated 7/16/18 at 1:55 AM staff found the resident on the floor beside the bed and apparently fell out of bed. He/she complained severe pain in left hip with inward rotation. He/she had lumps on left forehead area and rug abrasion on left shoulder. Licensed nurse G notified the physician who instructed to send the resident to the ER by EMS for evaluation. The next progress note was dated 7/20/18 at 4:00 PM indicated the resident was readmitted to the facility from the hospital where he/she had surgical placement of a rod in the left hip fracture. The fall intervention upon hospital return dated 7/20/18 included PT and occupational therapy, scoop mattress and a personal alarm.

Interview on 11/20/18 at 3:15 PM with administrator H confirmed the NSA/HSP lacked revision/amendment following the fall with fractures on 5/12/18 and altered care needs related to right arm sling, left leg immobilizer and non-weight bearing status. He/she confirmed the fall investigation for 6/27/18 failed to include whether the resident's feet where elevated in the recliner, whether staff followed the HSP at the time and the NS/HSP continued to lack a revision regarding the resident's status change.

The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and the negotiated service agreement regarding reduction of fall risks.

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S5155	Continued From page 10 - Record review for resident #191 revealed an admission date of 4/30/18 with diagnoses of dementia, depression, anxious mood, hypertension, lack of coordination and muscle weakness. The admission functional capacity screen (FCS) dated 4/30/18 indicated the resident had short and long-term memory deficit, impaired memory recall and decision making. He/she needed supervision with transfers/walking and physical assistance with toileting and bathing. He/she was at risk for falls and used a walker. The fall risk assessment dated 4/30/18 identified the resident with a score of 12 (10 or greater indicated high fall risk). The negotiated service agreement (NSA)/health service plan (HSP) dated 4/30/18 indicated the resident needed supervision related to cognitive impairment, confused to time and place with impaired decision making. He/she needed supervision with transfers/mobility with staff reminding the resident to use his/her walker and to retrieve the walker for him/her if he/she forgot. He/she needed physical assistance from staff for toileting. The NSA included a sheet titled Fall Intervention Plan dated 4/30/18 with noted new admission routine observation for 72 hours. ON 5/31/18 the facility began a new Fall Intervention Plan which included a listing of 38 different interventions a licensed nurse could use to reduce the risk of further falls. The sheet included the following additions: 9/7/18 - #7 (monitor closely post fall period with documentation for 24 hours) 10/14/18 - #7 Review of the resident's progress note revealed	S5155		

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licensed nurse G recorded on 9/7/18 at 6:00 PM resident appeared to trip while in the living room. He/she was found on the right side without injuries. No further notes about the fall or interventions to reduce further risks for falling with the next entry dated 10/14/18.

Review of the facility's incident report dated 9/7/18 at 3:40 PM revealed the resident with confusion in the living room and appeared to have tripped causing him/her to fall. The location noted as in front of the piano with no environmental factors marked. The incident report did not include how the staff knew or determined the resident had tripped, whether the resident used his/her walker or what may or may not have caused the resident to trip. The steps taken included make every effort to keep walking area free to allow good ambulation.

Review of the resident's progress note dated 10/14/18 at 5:00 AM resident wheeled him/herself about in a wheelchair, tried to reach for something and slid to the floor with no injuries noted. The note did not indicate if this was a witnessed fall or how staff determined the resident reached for something or why the resident was in a wheelchair with the FCS indicating the resident only used a walker.

Review of the facility's incident report dated 10/14/18 at 5:00 AM indicated the fall occurred in the living room area. The resident wheeled him/herself around in a wheelchair and while staff were out of the room he/she slid out of the chair either reaching for an item or trying to sit back. The notes indicated the resident was up at that time due to inability to sleep. The incident report did not include any statements from staff, any reason the resident was in a wheelchair when

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S5155	Continued From page 12 FCS indicated he/she walked with a walker. Observation on 11/20/18 at 12:55 PM revealed direct care staff E applied a gait belt, assisted the resident to stand from the dining room table and provided hands on assistance to walk the resident using a walker to the TV area. Interview on 11/20/18 at 1:35 PM with licensed nurse F said he/she thought staff had reviewed the camera video footage to determine the resident tripped. He/she confirmed the record lacked any documentation of this review to determine causal factors. He/she confirmed the intervention of #7 was an inappropriate intervention to reduce the risk of further falls. He/she said on the fall of 10/14/18 he/she had asked staff why the resident was in a wheelchair but did not include the interview and part of the incident investigation. He/she said staff indicated the resident had gotten another resident's wheelchair, used it to walk with and would not let staff change over to walker. He/she then at some point sat in the wheelchair and wheeled around. Nurse F confirmed intervention #7 was not appropriate intervention to reduce fall risks for this resident. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and the negotiated service agreement regarding reduction of fall risks.	S5155		