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	B087153	A. BUILDING: _____ B. WING _____	C 11/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORD SENIOR CARE INC - ROCKWOOD	6807 E ROCKWOOD ROAD WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the abbreviated survey of the above named facility for complaint #134893 conducted on 11/14/18 and 11/19/18.	S 000		
S5105 SS=E	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) The facility reported a census of 7 residents. The sample included 3 residents and 1 for focused review of safety. Based on observation, interview and record review the operator failed to ensure the written negotiated service agreement for each resident was based on the functional capacity screening and the service needs for 3 of 4 sampled residents (#119, #248 and #287) to include a description of services and provider of	S5105		

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

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S5105	Continued From page 1 each service. Findings included: - Record review for resident #119 revealed an admission date of 6/7/14 with diagnoses of dementia of Alzheimer's type with behavioral disturbances, delusion, hypertension, hypothyroidism, anxiety, major depressive disorder and lack of coordination. The annual functional capacity screen (FCS) dated 5/26/18 and compared to the significant change FCS on 5/20/17 indicated the resident was unable to perform any activities of daily living (ADLs) which included eating. The negotiated service agreement (NSA) dated 5/26/18 and without revision indicated the resident needed facility staff to provide total assist with eating and to provide a pureed/finger food diet. Review of the physician's orders revealed a faxed communication with a request to change the diet to a mechanical soft finger foods diet without any rationale for the change and signed by the physician on 4/19/18. Observation on 11/14/18 at 11:20 AM revealed the resident required staff to feed him/her and he/she had difficulty chewing due to no upper teeth. Interview on 11/14/18 at 3:15 PM with operator C confirmed he/she failed to revise/amend the NSA when the resident's diet changed to a mechanical soft finger food diet. The operator failed to ensure the written	S5105		

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S5105	Continued From page 2	S5105		

negotiated service agreement for this resident was based on the functional capacity screening and the service needs to include a description of services related to altered dietary needs.

- Record review for resident #287 revealed an admission date of 9/13/18 with a diagnosis of frontotemporal dementia.

The functional capacity screen dated 9/13/18 indicated the resident had wandering behavior and impaired decision making.

The negotiated service agreement (NSA) dated 9/13/18 indicated the resident needed assistance with bathing, shaving, personal hygiene, dressing, transfer, ambulation and medication administration. The section under nursing services to be supervised had none of the listed items marked as appropriate for the resident. The list included incontinence management, treatment management, behavioral management, personal care management and other. The NSA lacked any information regarding the resident's wandering behavior or impaired decision making for safety concerns.

Observation on 11/14/18 at 10:20 AM revealed the resident ambulated independently and wandered about the facility going from the living room area to the kitchen area and in the hallways. At 10:35 AM he/she wandered into the kitchen area and certified medication aide (CMA) A redirected him/her back to the living room area. At 10:48 AM the resident wandered into the kitchen area again while CMA A prepared the noon meal and CMA A redirected him/her back to the living room.

Interview on 11/14/18 at 3:15 PM with operator C

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confirmed the NSA did not include a description of services needed to address the resident's wandering behavior and impaired decision making regarding safety.

The operator failed to ensure the written negotiated service agreement for this resident was based on the functional capacity screening and the service needs to include a description of services and provider of each service related to behavior management.

- Record review for resident #248 revealed an admission date of 7/2/18 with diagnoses of bipolar disorder, hypertension, seizure, mental retardation and psychotic disorder.

The admission functional capacity screen dated 7/2/18 indicated the resident needed physical assistance with all activities of daily living except eating. He/she had impaired short and long-term memory, memory recall, decision making and had inappropriate behaviors.

The negotiated service agreement (NSA) dated 7/2/18 indicated the facility would provide assistance with bathing, dressing, personal hygiene, transfers and ambulation, in-home recreational activities and medication management. The section under nursing services to be supervised had only other - skin care psoriasis marked as appropriate for the resident from the typed list. The list included incontinence management, treatment management, behavioral management, personal care management and other. The NSA lacked any information regarding the resident's behaviors.

On 8/20/18 the plan of care included an addendum for a list of actions to take for

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S5105	Continued From page 4	S5105		

behaviors displayed by the resident. The NSA lacked a revision/addendum.

Review of the behavior log book revealed sporadic monitoring of behaviors for the resident beginning 8/21/18 which included yelling, cussing, hitting the walls and hitting staff or other residents.

A physician's order dated 9/19/18 directed the facility to admit the resident to a behavior unit related to acute and progressive psychosis with severe behaviors.

Physician's orders on 10/3/18 included readmission orders to the facility and directed to include behavior monitoring.

The discharge instructions/plan from the behavior unit dated 10/3/18 included a behavior and symptom management sheet for aggression/agitation. The directions included triggers, warning signs, coping skills and caregiver interventions. None of these were revised/amended on the NSA.

A behavior contract was initiated on 10/3/18 signed by the resident and guardian. The NSA lacked a revision/amendment to include this contract and the need for behavior management.

Interview on 11/14/18 at 3:15 PM with operator C confirmed the NSA did not include a description of services needed to address the resident's inappropriate behaviors and who would provide the services.

The operator failed to ensure the written negotiated service agreement for this resident was based on the functional capacity screening

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S5105	Continued From page 5 and the service needs to include a description of services and provider of each service related to behavior management.	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 7 residents. The sample included 3 residents and 1 for focused review of safety. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of each resident and in accordance with the functional capacity screening and negotiated service agreement for 2 of 4 sampled residents (#119 and #287). Findings included: - Record review for resident #119 revealed an admission date of 6/7/14 with diagnoses of dementia of Alzheimer's type with behavioral disturbances, delusion, hypertension,	S5155		

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hypothyroidism, anxiety, major depressive disorder and lack of coordination.

The annual functional capacity screen (FCS) dated 5/26/18 and compared to the significant change FCS on 5/20/17 indicated the resident was unable to perform any activities of daily living (ADLs) which included eating.

The negotiated service agreement dated 5/26/18 indicated the resident needed facility staff to provide total assist with eating and to provide a pureed/finger food diet.

The Health care plan last dated 3/20/18 directed staff to feed the resident, identified the resident as choke risk and directed if client is a choke risk there must be at least 2 staff at table with client. Licensed nurse B updated the care plan on 8/24/18 with mechanical soft finger foods diet.

Observation on 11/14/18 at 11:20 AM certified medication aide (CMA) A served the resident a plate with a bowl of beef (chunks greater than 1/2/inch and stringy) and noodles, in one compartment of the plate was mixed vegetables (corn, peas, carrots and green beans) whole and not mashed, and sliced peaches (about 1.5 inches long) in another compartment. CMA A left the resident at the table with the food and assisted another resident. No other staff was present at the table. At 11:28 AM CMA A sat beside the resident and began to feed him/her with no other staff in the dining room. At 11:33 AM CMA A needed to leave the table to assist another resident and no staff was present while resident #119 remained at the table with food in reach. The resident picked up a spoon and moved food around in the dishes and on the plate. At 11:56 AM CMA A asked operator C to sit with the

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resident while CMA A assisted another resident to bed. CMA A was in with the other resident until 12:15 PM. Observation at 12:20 PM revealed the resident at the table by him/herself and attempting to take bites.

Interview with CMA A on 11/14/18 at 12:15 PM revealed CMA A was the only staff present in the facility during the morning meal and sometimes the noon meal.

Interview with operator C on 11/14/18 at 3:15 PM revealed he/she was unaware the health care plan directed for 2 staff at the table related to choke risk. He/she confirmed not having 2 staff at the table with all meals.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of this resident and in accordance with the functional capacity screening and negotiated service agreement related to eating.

- Record review for resident #287 revealed an admission date of 9/13/18 with a diagnosis of frontotemporal dementia.

The functional capacity screen dated 9/13/18 indicated the resident had wandering behavior and impaired decision making.

The negotiated service agreement (NSA) dated 9/13/18 indicated the resident needed assistance with bathing, shaving, personal hygiene, dressing, transfer, ambulation and medication administration. The section under nursing services to be supervised had none of the listed items marked as appropriate for the resident. The list included incontinence management, treatment

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management, behavioral management, personal care management and other. The NSA lacked any information regarding the resident's wandering behavior or impaired decision making for safety concerns.

During the initial tour on 11/14/18 at 10:05 AM revealed an unlocked common bathroom under construction with the door partially open and a light on. Inside the room was a hammer, a reciprocating saw, a skill saw, screws and nails and bare wood on the floor with rough edges.

Observation on 11/14/18 at 10:20 AM revealed the resident ambulated independently and wandered about the facility going from the living room area to the kitchen area and in the hallways. At 10:35 AM he/she wandered into the kitchen area and certified medication aide (CMA) A redirected him/her back to the living room area. At 10:48 AM the resident wandered into the kitchen area again while CMA A prepared the noon meal and CMA A redirected him/her back to the living room. At 12:15 PM CMA A returned to the kitchen area from another resident's room, operator C came out of the employee's bathroom and no one supervised resident #287 as he/she wandered about in the kitchen area from the direction of the hallway with the bathroom under construction.

Interview on 11/14/18 at 3:15 PM with operator C confirmed the NSA did not include a description of services needed to address the resident's wandering behavior and impaired decision making regarding safety. He/she confirmed the construction area needed to be locked for safety. He/she confirmed when the only staff on duty had to care for other residents that left this resident unsupervised with wandering behavior.

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S5155	Continued From page 9 The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of each resident and in accordance with the functional capacity screening and negotiated service agreement related to safety for impaired decision making and wandering behavior.	S5155		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (a)(c) The facility reported a census of 7 residents. The sample included 3 residents and 1 focused review for safety. Based on observation, interview and record review the operator failed to ensure staff provided the mechanically altered diet for 1 of 2 residents sampled for nutrition (#119) in	S5185		

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accordance with the negotiated service agreement, a medical care provider's order and instructions from a medical care provider or licensed dietitian.

Findings included:

- Record review for resident #119 revealed an admission date of 6/7/14 with diagnoses of dementia of Alzheimer's type with behavioral disturbances, delusion, hypertension, hypothyroidism, anxiety, major depressive disorder and lack of coordination.

The annual functional capacity screen (FCS) dated 5/26/18 and compared to the significant change FCS on 5/20/17 indicated the resident was unable to perform any activities of daily living (ADLs) which included eating.

The negotiated service agreement dated 5/26/18 indicated the resident needed facility staff to provide total assist with eating and to provide a pureed/finger food diet.

The Health care plan last dated 3/20/18 directed staff to feed the resident and identified the resident as choke risk. Licensed nurse B updated the care plan on 8/24/18 with mechanical soft finger foods diet.

Review of the physician's orders revealed a faxed communication with a request to change the diet to a mechanical soft finger foods diet without any rationale for the change and signed by the physician on 4/19/18. The record did not include written instructions on the specifics of the mechanical soft finger foods diet.

On 11/14/18 at 12:20 PM operator C provided an

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instruction sheet from Drugs.com website for instructions on a soft diet. He/she confirmed the resident's record lacked instructions on the mechanical soft finger foods diet from the medical care provider or a licensed dietician. The reference provided directed to cut food into small pieces that are 1/2 inch or smaller in size because they are easier to swallow. Cook vegetables until they are soft enough to be mashed with a fork, use broth, gravy or sauces to moisten meats. Use a food processor to grind or puree foods to make them easier to chew and swallow. Use fruit juice to blend fruit and strain soups that have pieces of meat or vegetable that are larger than 1/2 inch. Foods to avoid included corn and peas and casseroles with large chunks of meat.

Observation on 11/14/18 at 11:20 AM revealed certified medication aide (CMA) A served the resident a plate with a bowl of beef (chunks greater than 1/2 inch with stringy strands) and noodles, in one compartment of the plate was mixed vegetables (corn, peas, carrots and green beans) whole and not mashed, and sliced peaches (about 1.5 inches long) in another compartment. CMA A fed the residents bites of food without altering the size of the bites or mashing up the vegetables. The resident appeared to chew the food at the front of his/her mouth. CMA A reported the resident only had bottom teeth. The resident moved food around in the dishes and on the plate with a spoon and CMA A helped to get the food into the resident's mouth. At 12:20 PM observation revealed the resident at the table by him/herself and was attempting to take bites. He/she got a bite of the beef which was about 1 and 1/2 inches in length with long strands. As the resident got the meat to his/her mouth CMA A entered the dining room

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S5185	Continued From page 12 and intervened to cut the meat into smaller pieces. Interview on 11/14/18 at 12:15 PM with CMA A revealed the resident was on a pureed diet in January 2018 because of no teeth to chew and then he/she would not eat the pureed diet, lost weight so the nurse asked to change it to mechanical soft. He/she usually cooked the meat extra-long, so it was soft, and he/she will cut up the meat. He/she did not know of any specific instructions about the resident's mechanical soft finger foods diet. Interview on 11/14/18 at 11:43 AM with operator C revealed he/she prepared the menus. He/she reported having an instruction sheet for the pureed diet but had to look for the mechanical soft diet and reported meats needed to be ground up if bigger than 1/2 inch, tough or stringy. He/she did not have a menu which included finger foods. The operator failed to ensure staff provided the mechanically altered diet for this resident in accordance with the negotiated service agreement, a medical care provider's order and instructions from a medical care provider or licensed dietitian.	S5185		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.	S5251		

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S5251	Continued From page 13 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 1 for focused review of safety. Based on 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 2 of 4 sampled residents (#210 and #248). Findings included: - Record review for resident #210 revealed an admission date of 9/30/18 with diagnoses of Parkinson's, dementia, hypertension and chronic obstructive pulmonary disease. The admission functional capacity screen dated 9/30/18 indicated the resident had impaired short and long-term memory, memory recall and decision making. He/she needed physical assistance with bathing and dressing. The negotiated service agreement dated 9/30/18 indicated facility staff would provide assistance with all activities of daily living including transfer and ambulation assist. The health care plan dated 9/30/18 directed staff to assist with all transfers, toileting and ambulation. Record review revealed a single page of wellness notes with entries dated 9/30/18, 10/2/18, 10/6/18 and 10/25/18. None of these notes included	S5251		

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ACCORD SENIOR CARE INC - ROCKWOOD	6807 E ROCKWOOD ROAD WICHITA, KS 67206

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information about the resident having pain in the right elbow and/or received treatment for an acute condition related to the right elbow pain. The October 2018 monthly nursing note included suspected gout right elbow and pain in right elbow but no assessment of the elbow by the nurse.

Interview on 11/14/18 at 12:10 PM with certified medication aide (CMA) A revealed the resident had completed an antibiotic last Friday (11/9/18) for cellulitis of the right elbow but he/she still had some pain with it.

Interview on 11/14/18 at 3:15 PM with operator C confirmed the resident received an antibiotic and the notes lacked any information about the illness, action taken or results of the action.

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 this resident.

- Record review for resident #248 revealed an admission date of 7/2/18 with diagnoses of bipolar disorder, hypertension, seizure, mental retardation and psychotic disorder.

The admission functional capacity screen dated 7/2/18 indicated the resident needed physical assistance with all activities of daily living except eating. He/she had impaired short and long-term memory, memory recall, decision making and had inappropriate behaviors.

The negotiated service agreement (NSA) dated 7/2/18 indicated the facility would provide assistance with bathing, dressing, personal

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hygiene, transfers and ambulation, in-home recreational activities and medication management. The section under nursing services to be supervised had only other - skin care psoriasis marked as appropriate for the resident from the typed list. The list included incontinence management, treatment management, behavioral management, personal care management and other. The NSA lacked any information regarding the resident's behaviors.

The health care plan (HCP) dated 7/2/18 indicated the resident needed assistance with dressing/grooming, transfers, toileting and ambulation. The HCP lacked information about the resident's behaviors.

On 8/20/18 the plan of care included an addendum for a list of actions to take for behaviors displayed by the resident.

Review of the behavior log book revealed sporadic monitoring of behaviors for the resident beginning 8/21/18 which included yelling, cussing, hitting the walls and hitting staff or other residents. The next sheet was dated 8/25/18 through 8/28/18, none for 8/29/18, then 8/30/18 and 8/31/18 with none until 9/4/18 through 9/7/18, none on 9/8/18, and then 9/9/18 through 9/12/18 then none until 9/15/18 through 9/19/18 when he/she was admitted to a behavior unit. The next log was dated 10/4/18 then none until 10/15/18 and 10/16/18. The next log began on 11/8/18 through 11/12/18 when he/she was admitted to behavior unit.

A physician's order dated 9/19/18 directed the facility to admit the resident to a behavior unit related to acute and progressive psychosis with severe behaviors.

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S5251	Continued From page 16 Physician's orders on 10/3/18 included readmission orders to the facility and directed to include behavior monitoring. The discharge instructions/plan from the behavior unit dated 10/3/18 included a behavior and symptom management sheet for aggression/agitation. The directions included triggers, warning signs, coping skills and caregiver interventions. A behavior contract was initiated on 10/3/18 signed by the resident and guardian. Review of the wellness notes between 10/3/18 through 11/12/18 revealed the following entries: 10/3/18 readmit from behavior unit, safety evaluation done, discussed behavior contract with durable power of attorney (DPOA) 10/4/18 at 2:00 PM licensed nurse B received report from certified medication aide (CMA) A the resident had been demanding, impatient and followed by hitting staff, bulldozing staff with wheelchair, reminded of contract and alerted family of the resident's behaviors. 10/16/18 6:45 PM licensed nurse B called the DPOA to confirm medication changes of adding Clonazepam three times a day. 10/27/18 at 1:00 PM licensed nurse B received a call from a CMA of resident having increased behaviors and mad at CMA for not pulling up the covers. Licensed nurse B redirected the resident and provided the CMA with techniques. 10/27/18 at 6:00 PM licensed nurse B was notified the resident continues with behaviors...upon arrival by nurse B resident was yelling at staff, difficult to redirect, wheeled self in wheelchair to his/her room and was hitting the walls aggressively with wheelchair and arms.	S5251		

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S5251	Continued From page 17 The next entry was a letter to the DPOA dated 10/29/18 about the behaviors and possible need for family to provide 1 on 1 supervision. It included changes in the resident's urination and obtaining a sample. The next note was dated 11/12/18 by licensed nurse B about events over the weekends regarding behaviors. On 10/28/18 physician extender D ordered Macrobid 100 milligrams every 12 hours for 5 days after a urinalysis indicated a urinary tract infection. The nursing notes lacked any information about the treatment or results of the action taken. Interview with operator C on 11/14/18 at 3:15 PM confirmed the behavior monitoring as sporadic. He/she confirmed the nursing notes failed to include information of the resident's indicators for a urinary tract infection, actions taken and results of the actions. 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 this resident.	S5251		
S5255 SS=E	26-42-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement.	S5255		

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S5255	Continued From page 18 This REQUIREMENT is not met as evidenced by: KAR 26-42-102 (a) The facility reported a census of 7 residents. The sample included 3 residents and 1 for focused review of safety. Based on observation, interview and record review the operator failed to ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident's functional capacity screening, negotiated service agreement and health care plan for 1 of 4 sampled residents (#119). Findings included: - Record review for resident #119 revealed an admission date of 6/7/14 with diagnoses of dementia of Alzheimer's type with behavioral disturbances, delusion, hypertension, hypothyroidism, anxiety, major depressive disorder and lack of coordination. The annual functional capacity screen (FCS) dated 5/26/18 and compared to the significant change FCS on 5/20/17 indicated the resident was unable to perform any activities of daily living (ADLs) which included eating. The negotiated service agreement dated 5/26/18 indicated the resident needed facility staff to provide total assist with eating and to provide a pureed/finger food diet. The Health care plan last dated 3/20/18 directed staff to feed the resident, identified the resident as choke risk and directed if client is a choke risk	S5255		

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there must be at least 2 staff at table with client. Licensed nurse B updated the care plan on 8/24/18 with mechanical soft finger foods diet.

Observation on 11/14/18 at 11:20 AM certified medication aide (CMA) A served the resident a plate with a bowl of beef (chunks greater than 1/2 inch with stringy strands) and noodles, in one compartment of the plate was mixed vegetables (corn, peas, carrots and green beans) whole and not mashed, and sliced peaches (about 1.5 inches long) in another compartment. CMA A left the resident at the table with the food and assisted another resident. No other staff was present at the table. At 11:28 AM CMA A sat beside the resident and began to feed him/her with no other staff in the dining room. At 11:33 AM CMA A needed to leave the table to assist another resident and no staff was present while resident #119 remained at the table with food in reach. The resident picked up a spoon and moved food around in the dishes and on the plate. At 11:56 AM CMA A asked operator C to sit with the resident while CMA A assisted another resident to bed. CMA A was in with the other resident until 12:15 PM. Observation at 12:20 PM revealed the resident at the table by him/herself and attempting to take bites.

Interview with CMA A on 11/14/18 at 12:15 PM revealed CMA A was the only staff present in the facility during the morning meal and sometimes the noon meal.

Interview with operator C on 11/14/18 at 3:15 PM revealed he/she was unaware the health care plan directed for 2 staff at the table related to choke risk. He/she confirmed not having 2 staff at the table with all meals.

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S5255	Continued From page 20 The operator failed to ensure a sufficient number of qualified staff to provide resident #119 with the services in accordance with his/her resident's negotiated service agreement and health care service plan that identified at least 2 staff to be at the table with the resident when only 1 staff was on duty.	S5255		