STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B030013	A. BUILDING: _____ B. WING _____	10/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTCARE HOMES OF OTTAWA, LLC	27 E ROCKWOOD DRIVE OTTAWA, KS 66067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named facility on 10/1/18, 10/2/18, 10/3/18,10/4/18 and 10/8/18.	S 000		
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 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: 101(f)(3)(A)(B)(C)(D)(E)(F)	S5028		

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

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S5028	Continued From page 1 The facility identified a census of 9 residents. The sample included 3 residents. Based on record review, interview, and observation for 3 (#100, #200, #300) of 3 residents sampled, the operator failed to ensure each allegation of abuse, neglect, or exploitation shall be reported to the operator as soon as staff aware of allegation and to the department within 24 hours. The operator shall ensure that an investigation started, immediate measure taken to prevent further potential abuse, neglect or exploitation while investigation in progress, report results of investigation within five working days, take appropriate action, complete the department's complaint investigation report and submit within five working days, and maintain a written report of each investigation. Findings included: - Record review for resident #100 on 10/2/18 at 10:20 a.m. revealed an admit date of 2/13/16 with diagnoses of dementia with behaviors, anxiety, and hypertension. The functional capacity screen dated 2/22/18 recorded resident required supervision with dressing, toileting, transfer, walking/mobility, bladder incontinence, physical assistance with bathing, eating, experienced short-term memory loss, memory recall, long term memory loss, decision making, hard of hearing, impaired decision making, and falls/unsteadiness. The NSA/HCS dated 2/12/18 recorded resident required one to two staff assistance with bathing due to resident being resistive with care and required physical assistance with dressing. Staff to supervise resident and assist with toileting and	S5028		

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S5028	Continued From page 2 ambulation. Bed alarm to be in place to alert staff to resident needing assistance. History and physical dated 8/12/18 recorded injury from fall: broken nose with nasal laceration and C1 fracture. The nurses notes recorded the following: 9/28/18 at 1:30 p.m. This employee was opening medication cabinet and other employee was at the trash can dumping plates. Resident was handed a cup cake to eat just moments before and while staff was doing above task the staff by trash can heard a thud and found resident lying on back in doorway. Both employees went to resident and observed blood coming from the back of resident's head. Nurse on call notified. Nurse instructed staff to call 911 and apply pressure with rag until EMS arrived. EMS arrived and took resident to hospital. Family notified of fall. Signed certified staff E. Interview on 10/2/18 at 4:00 p.m. with licensed nurse G stated licensed nurse A informed him/her he/she notified the Department of the fall with injury. Review of department records with no report of potential neglect for resident #100 received. For resident #100, the operator failed to ensure allegations of potential neglect were reported to the department within 24 hours, an investigation was initiated immediately, and a written record of the investigation was submitted to the department and maintained at the facility when a resident who required supervision with ambulation was found on the floor with a laceration to the back of his/her	S5028		

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S5028	Continued From page 3 head. - Record review for resident #200 revealed an admit date of 10/20/14 with diagnoses of dementia, parkinson's disease, hypertension, and cerebral vascular accident. The functional capacity screen dated 10/5/17 recorded resident required physical assistance with eating, unable to assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired hearing, vision, and decision making. Resident has not experienced falls/unsteadiness. The NSA/HCS dated 10/5/17 record resident required mechanically soft diet and staff to assist with feeding resident. Hospice staff to provide two showers a week and facility staff will provide showers as needed. Resident requires complete care for showers. Facility staff will provide complete care for toileting process, dressing, undressing, assistance with transfers, use hoyer lift with two staff for transfers, and one staff can push resident when in high back chair. Resident is hard of hearing and communication can be difficult. Staff will provide a visual check every four hours, check, change, and reposition at midnight and 4:00 a.m. per family request. The nurses notes recorded: 8/22/18 at 6:00 a.m. "Resident has a large purple and red mark on right arm. Not sure what it is from." Signed certified staff K. The record lacked documentation notification of the department of potential abuse and neglect	S5028		

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S5028	Continued From page 4 and of an investigation of the cause of the mark on the arm to rule out potential abuse and neglect. 8/28/18 at 2:20 p.m. "This morning when helping resident to get up for the day staff noticed a large dark purple spot on resident's right shin. Staff unaware of what caused it and nurse on call notified. . ." Signed certified staff E. The record lacked documentation notification of the department of potential abuse and neglect and of an investigation of the cause of dark purple spot on the shin to rule out potential abuse and neglect. 9/13/18 at 10:10 a.m. "Received call approximately at 1:00 a.m. reporting staff heard resident bed alarm. Upon entering bedroom, resident was found in a sitting position on fall mat with back resting against bed. Staff reported resident denied pain and instructed staff to get resident up and back to bed and obtain vital signs. Unable to locate vital signs this morning. Checked on resident and now noted to have approximately 5-inch bruising above right ankle and going upwards. When asked resident if trying to get up, resident nodded head yes and asked if ok, resident nodded yes. Medical care provider notified and no new orders". Signed licensed nurse C. The record lacked documentation notification of the department of potential abuse and neglect and of an investigation of the cause of fall and bruise to the right ankle to rule out potential abuse and neglect. For resident #100, the operator failed to ensure allegations of potential neglect were reported to	S5028		

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S5028	Continued From page 5	S5028		

the department within 24 hours, an investigation was initiated immediately, and a written record of the investigation was submitted to the department and maintained at the facility when a resident who required total assistance with all ADLs was found with indications of injury on 2 different occasions and found on the floor.

- Record review for resident #300 revealed an admit date of 3/17/15 with diagnoses of lewy body dementia and osteoporosis.

The functional capacity screen dated 3/17/18 recorded resident unable to assist with bathing dressing, toileting, transfer, walking/mobility, eating, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, socially disruptive inappropriate behaviors, and falls/unsteadiness.

The NSA/HCS dated 3/17/18 recorded resident on hospice . .. Resident is incontinent and required total care. Staff to check every two hours, change and provide peri-care each time. Resident required total assistance with dressing/undressing, is non-ambulatory with brada chair. Staff to ensure resident is propelled to needed area. Keep pummel cushion in brada chair. Resident has hospital bed and ½ side rail provided by hospice. Bed alarm in place to alert staff of potential need for assistances.

The nurses notes record the following:

8/11/18 at 10:33 a.m., Resident's bed alarm was sounding, and staff immediately went to resident's room. When staff entered the room, resident was on the floor next to bed lying down. Resident had

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S5028	Continued From page 6 no complaints of pain or discomfort. Nurse on call notified and assessed resident over phone and gave staff the ok to get resident up. No pain or discomfort. Observed a small scratch on resident's left upper thigh area. Family notified of fall. Nurse also instructed staff to put a fall mat beside resident's bed when resident in bed. Signed certified staff D. 8/19/18 at 5:15 a.m. When I arrived at 6:00 p.m. on 8/18/18 this writer was informed that resident had fallen. Staff had found resident on floor at 3:00 p.m. Resident was previously in recliner and slid out. Staff did inform on call nurse when happened. Signed certified staff K. For resident #300, the operator failed to ensure allegations of potential neglect were reported to the department within 24 hours, an investigation was initiated immediately, and a written record of the investigation was submitted to the department and maintained at the facility when a resident who required total assistance with all ADLs was found on the floor on two occasions.	S5028		
S5066 SS=E	26-42-200 (b) Resident Criteria Restraints (b) Each administrator or operator shall ensure that any resident whose clinical condition requires the use of physical restraints is not admitted or retained. This REQUIREMENT is not met as evidenced by: KAR 26-42-200 (b)	S5066		

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S5066	Continued From page 7 The facility identified a census of 9 residents. The sample included 3 residents. Based on record review, interview, and observations for 2 (#100, #300) of 3 residents sampled, the operator failed ensure a resident whose clinical condition required the use of a physical restraint was not admitted or retained. Findings included: - Record review for resident #200 revealed an admit date of 10/20/14 with diagnoses of dementia, parkinson's disease, hypertension, and cerebral vascular accident. The functional capacity screen dated 10/5/17 recorded resident required physical assistance with eating, unable to assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired hearing, vision, and decision making. Resident has not experienced falls/unsteadiness. The NSA/HCS dated 10/5/17 record resident required mechanically soft diet and staff to assist with feeding resident. Hospice staff to provide two showers a week and facility staff will provide showers as needed. Resident requires complete care for showers. Facility staff will provide complete care for toileting process, dressing, undressing, assistance with transfers, use hoyer lift with two staff for transfers, and one staff can push resident when in high back chair. Resident is hard of hearing and communication can be difficult. Staff will provide a visual check every four hours, check, change, and reposition at	S5066		

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S5066	Continued From page 8 midnight and 4:00 a.m. per family request. The nurses notes recorded: 9/13/18 at 10:10 a.m. "Received call approximately at 1:00 a.m. reporting staff heard resident bed alarm. Upon entering bedroom, resident was found in a sitting position on fall mat with back resting against bed. Staff reported resident denied pain and instructed staff to get resident up and back to bed and obtain vital signs. Unable to locate vital signs this morning. Checked on resident and now noted to have approximately 5-inch bruising above right ankle and going upwards. When asked resident if trying to get up, resident nodded head yes and asked if ok, resident nodded yes. Medical care provider notified and no new orders". Signed licensed nurse C. On 10/2/18 at 11:45 a.m. observed certified staff E and D provide incontinent care to resident #200 in bed. Certified staff E and D then placed hoyer lift sling under resident and transferred to high back wheel chair. Noted ½ side rail and bed alarm on bed. Resident unable to assist with transfer. Certified staff E stated ½ side rail on side of bed to keep resident from falling out of bed. Interview on 10/2/18 at 4:00 p.m. with licensed nurse A stated not aware side rails being used. The resident record lacked documentation of an assessment that the side rail did not create a physical restraint for the resident. For resident #100, the operator failed ensure a resident whose clinical condition required the use of a physical restraint was not admitted or retained.	S5066		

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S5066	Continued From page 9	S5066		

- Record review for resident #300 revealed an admit date of 3/17/15 with diagnoses of Lewy body dementia and osteoporosis.

The functional capacity screen dated 3/17/18 recorded resident unable to assist with bathing dressing, toileting, transfer, walking/mobility, eating, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, socially disruptive inappropriate behaviors, and falls/unsteadiness.

The NSA/HCS dated 3/17/18 recorded resident on pureed diet and fed by staff and staff to offer supplemental drink if resident eats less than 50% of meal. Resident on hospice with hospice home health aide to give two showers a week and facility staff to shower as needed. Resident is incontinent and required total care. Staff to check every two hours, change and provide peri-care each time. Resident required total assistance with dressing/undressing, is non-ambulatory with broda chair. Staff to ensure resident is propelled to needed area. Keep pummel cushion in broda chair. Resident has hospital bed and ½ side rail provided by hospice. Bed alarm in place to alert staff of potential need for assistances.

The nurses notes record the following:
8/11/18 at 10:33 a.m., Resident's bed alarm was sounding and staff immediately went to resident's room. When staff entered the room, resident was on the floor next to bed lying down. Resident had no complaints of pain or discomfort. Nurse on call notified and assessed resident over phone and gave staff the ok to get resident up. No pain or discomfort. Observed a small scratch on resident's left upper thigh area. Family notified of fall. Nurse also instructed staff to put a fall mat

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S5066	Continued From page 10 beside resident's bed when resident in bed. Signed certified staff D. 8/13/18 at 5:30 a.m. Resident was in bed when I got here. Around 6:30 p.m. staff went in to change resident and (his/her) legs were hanging out of bed. Staff put legs back in bed and when moved legs (he/she) let out a loud scream. On call nurse notified and told staff to administer morphine .5 cubic centimeters (CC's). About 1:00 a.m. resident calmed down. Signed certified staff K. On 10/2/18 at 11:10 a.m. observed certified staff D and E provide incontinent care to resident #300. Noted bed in low position with ½ side rail up on side of bed not against the wall. Observed a pad alarm on bed. Resident slept through incontinent care provided. Certified staff E stated side rail was up on bed because resident had fallen out of bed. Certified staff E further stated resident is unable to bear any weight, assist with any care and is a full two-person transfer. Interview on 8/2/18 at 4:00 p.m. with licensed nurse G stated was not aware of reason for side rail on the bed. The resident record lacked documentation of an assessment that the side rail did not create a physical restraint for the resident. For resident #300, the operator failed ensure a resident whose clinical condition required the use of a physical restraint was not admitted or retained.	S5066		

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S5066	Continued From page 11 For residents #100 and #300, the operator failed ensure a resident whose clinical condition required the use of a physical restraint was not admitted or retained.	S5066		
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. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility identified a census of 9 residents. The sample included 3 residents. Based on record review, interview, and observations for 3 (#100, #200. #300) of 3 residents sampled, the operator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services to meet the needs of the resident. Resident #100 experienced a fall with fracture and facial injury on 8/12/18 and an additional fall on 8/17/18; the licensed nurse failed to implement interventions to address increased unsteadiness and fall risk. Resident #100 experienced a fall on 9/28/18 that resulted in a head laceration that required six staples.	S5155		

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S5155	Continued From page 12 Findings included: - Record review for resident #100 on 10/2/18 at 10:20 a.m. revealed an admit date of 2/13/16 with diagnoses of dementia with behaviors, anxiety, and hypertension. The functional capacity screen (FCS) dated 2/22/18 recorded resident required supervision with dressing, toileting, transfer, walking/mobility, bladder incontinence, physical assistance with bathing, eating, experienced short-term memory loss, memory recall, long term memory loss, decision making, hard of hearing, impaired decision making, and falls/unsteadiness. The negotiated service agreement/health care service plan (NSA/HCS) dated 2/12/18 recorded resident required one to two staff assistance with bathing due to resident being resistive with care and required physical assistance with dressing. Staff to supervise resident and assist with toileting and ambulation. Bed alarm to be in place to alert staff to resident needing assistance. The NSA/HCS lacked documentation that indicated resident required the use of a walker when ambulating. History and physical dated 8/12/18 recorded injury from fall: broken nose with nasal laceration and C1 fracture. The nurses notes recorded the following: 6/12/18 at 10:15 a.m. "This nurse notified that resident was on floor in room. I went to room to find resident sitting on bedroom floor on blanket next to bed. Fall was witnessed by roommate who stated resident rolled out of bed. No injuries	S5155		

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S5155	Continued From page 13	S5155		

or discomfort noted. Resident put back to bed." Signed licensed nurse J.

8/12/18 at 5:45 a.m. "Resident got up in middle of the night and wandered to the living room. Staff went to tell resident it was the middle of the night and started to walk (him/her) to room; staff turned to open door, heard (resident) stumble and attempted to catch (him/her). Resident fell and hit face on the floor. The on-call nurse was called and informed staff to notify family and if they did not answer to call 911. Family did not answer so we called 911 paramedics came and got resident and left around 2:30 a.m. As of 6:20 a.m. family member and resident still at hospital." Signed certified staff K.

8/13/18 at 7:40 a.m. "Received multiple calls on 8/12/18 early morning. Informed of resident falling with facial injuries. Instructed staff to try and call family and 911. Hospital called with questions concerning when resident had tetanus shot and thought resident would be returning shortly. Approximately 4:30 a.m. received another call from hospital stating resident had cervical fracture and damage to nose, was going to be transported to another hospital." Signed licensed nurse B.

8/13/18 at 9:00 p.m. "Resident returned to facility at 9:15 p.m. via private auto. Diagnosis: Acute nondisplaced fracture along left posterior arch of C1 and cervical spondylosis. Follow up appointment in one week with Ears/Nose/Throat (ENT) doctor." Signed licensed nurse C.

8/14/18 at 5:50 a.m. "Resident has to have help when up walking around, very unsteady and wobbly. When taken to restroom required physical assist. When resident would get up was

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assisted by one to two staff multiple times throughout the night. Resident keeps picking at sore on nose and poking (his/her) face. Resident's face is puffy, purple, and red." Signed certified staff K.

8/14/18 at 7:30 a.m. "Arrived at facility, resident sitting at side of bed with caregiver. Sponge bath given with resident requiring assistance. Face is swollen with both eyes and most of face being bruised. Laceration on nose approximately 1 - 1 1/2 inches long with one steri-strip remaining in place. Area scabbed over. Resident reported to have difficulty with ambulation this morning with body wanting to lean backwards causing unsteadiness. Ambulate with staff assist to dining room." Signed licensed nurse B.

NSA/HCS lacked interventions to address increased difficulty with ambulation and fall risk.

8/14/18 at 8:35 a.m. "called medical care provider and received orders to resume previous medications prior to hospitalization. Received new order for Occupational and Physical therapy (OT/PT) evaluation and treat due to fall/unsteady gait. . . .". Signed licensed nurse B.

8/15/18 at 1:15 p.m. PT here working with resident upon my arrival at 11:30 a.m. and spoke to resident about using the walker. OT here to work with resident. Signed licensed nurse B.

NSA/HCS lacked documentation of interventions to address fall risk and OT/PT services.

8/17/18 at 8:00 p.m. "Came around the corner into the kitchen and saw resident walking from kitchen into the dining room. Right when caregiver got close to resident, (he/she) lost

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balance falling to the floor landing on right side at 6:25 p.m. On call nurse notified at 6:45 p.m. Family notified of fall." Signed certified staff L.

The record lacked documentation of an assessment performed by a licensed nurse,

8/18/18 at 2:00 p.m. "Resident spent most of morning sleeping and had been pleasant with staff." Signed certified staff M.

8/19/18 at 5:00 a.m. "Resident has been in bed most of the evening and night, has not been feeling good, and would not specify what was wrong. Resident has been very sleepy and required physical assistance with walking all night." No complaint of pain. Signed certified staff K.

8/19/18 at 1:10 p.m. "Resident up this morning and would not stay and eat breakfast but kept going back to bed and then get up a few minutes later and eat a few bites. Resident repeated this 3 times during meal. Staff followed resident each time. Resident was helped to the living room and very unsteady. . . " Signed certified staff E.

8/20/18 at 8:15 a.m. "Resident required stand by assistance when aware resident up or wanting to get up. Showed unsteadiness on feet several times this morning.. . " . Signed licensed nurse B.

NSA/HCS lacked documentation of interventions to address unsteadiness and fall risk.

9/28/18 at 1:30 p.m. "This employee was opening medication cabinet and other employee was at

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the trash can dumping plates. Resident was handed a cup cake to eat just moments before and while staff was doing above task the staff by trash can heard a thud and found resident lying on back in doorway. Both employees went to resident and observed blood coming from the back of resident's head. Nurse on call notified. Nurse instructed staff to call 911 and apply pressure with rag until EMS arrived. EMS arrived and took resident to hospital. Family notified of fall." Signed certified staff E.

9/28/18 at 4:45 p.m. "Resident returned to facility via private auto with family. Alert to self. Received 6 staples to back of head. Vital signs B/P 120/93, P 78, R 16, T 98.2. Follow up for removal of staples in seven to fourteen days." Signed licensed nurse C.

NSA/HCS lacked documentation of interventions to address continued fall risk and care of laceration with staples.

9/30/18 at 6:30 a.m. Resident had a good night but very sleepy. Staff assisted to bathroom all night. When resident has been up staff has been beside resident. Signed certified staff K.

On 10/2/18 at 12:25 p.m. Observed resident in bed. Certified staff D assisted resident up to toilet with unsteady gait. Observed 6 staples in occipital area on back of head. Dried blood noted around area. Resident ambulated with walker and assistance of certified staff D. At 12:35 p.m. resident attempted to put walker up and ambulate without it from dining room table. Certified staff D and E in dining room preparing lunch along with licensed nurse A. At 12:40 p.m. observed

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resident get up from chair by self and ambulate from dining room table to kitchen area without walker. Observed unsteady gait and ambulated approximately eight feet. Licensed nurse A grabbed resident and ambulated with him/her back to dining room table and provided lunch for him/her to eat. Certified staff E stated usually two staff on duty and a licensed nurse will come by facility during the day to check on residents. Additional staff in facility this date included licensed nurse A and operator/RN N who were here due to the survey.

For resident #100 the operator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services to meet the needs of the resident and resident #100 experienced two falls with injury.

Record review for resident #200 revealed an admit date of 10/20/14 with diagnoses of dementia, Parkinson's disease, hypertension, and cerebral vascular accident.

The functional capacity screen dated 10/5/17 recorded resident required physical assistance with eating, unable to assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired hearing, vision, and decision making. Resident has not experienced falls/unsteadiness.

The NSA/HCS dated 10/5/17 record resident required mechanically soft diet and staff to assist with feeding resident. Hospice staff to provide two showers a week and facility staff will provide showers as needed. Resident requires complete care for showers. Facility staff will provide

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complete care for toileting process, dressing, undressing, assistance with transfers, use hoyer lift with two staff for transfers, and one staff can push resident when in high back chair. Resident is hard of hearing and communication can be difficult. Staff will provide a visual check every four hours, check, change, and reposition at midnight and 4:00 a.m. per family request.

The nurses notes recorded:
9/13/18 at 10:10 a.m. "Received call approximately at 1:00 a.m. reporting staff heard resident bed alarm. Upon entering bedroom, resident was found in a sitting position on fall mat with back resting against bed. Staff reported resident denied pain and instructed staff to get resident up and back to bed and obtain vital signs. Unable to locate vital signs this morning. Checked on resident and now noted to have approximately 5-inch bruising above right ankle and going upwards. When asked resident if trying to get up, resident nodded head yes and asked if ok, resident nodded yes. Medical care provider notified and no new orders". Signed licensed nurse C.

On 10/2/18 at 11:45 a.m. observed certified staff E and D provide incontinent care to resident #200 in bed. Certified staff E and D then placed hoyer lift sling under resident and transferred to high back wheel chair. Noted ½ side rail and bed alarm on bed. Resident unable to assist with transfer. Certified staff E stated ½ side rail on side of bed to keep resident from falling out of bed.
Interview on 10/2/18 at 4:00 p.m. with licensed nurse A stated not aware side rails being used.

The NSA/HCS lacked documentation of use of a fall mat and bed alarm. NSA/HCS also lacked a

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description of service related to the ½ side rail up, including monitoring the resident's ability to use it safely, and the safety of the device to address the risk for entrapment.

For resident #200 the operator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services to meet the needs of the resident related to intervention to address fall risk and use of a side rail.

- Record review for resident #300 revealed an admit date of 3/17/15 with diagnoses of lewy body dementia and osteoporosis.

The functional capacity screen dated 3/17/18 recorded resident unable to assist with bathing dressing, toileting, transfer, walking/mobility, eating, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, socially disruptive inappropriate behaviors, and falls/unsteadiness.

The NSA/HCS dated 3/17/18 recorded resident on pureed diet and fed by staff and staff to offer supplemental drink if resident eats less than 50% of meal. Resident on hospice with hospice home health aide to give two showers a week and facility staff to shower as needed. Resident is incontinent and required total care. Staff to check every two hours, change and provide peri-care each time. Resident required total assistance with dressing/undressing, is non-ambulatory with broda chair. Staff to ensure resident is propelled to needed area. Keep pummel cushion in broda chair. Resident has hospital bed and ½ side rail provided by hospice. Bed alarm in place to alert

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S5155	Continued From page 20 staff of potential need for assistances. The nurses notes record the following: 8/11/18 at 10:33 a.m., 'Resident's bed alarm was sounding and staff immediately went to resident's room. When staff entered the room, resident was on the floor next to bed lying down. Resident had no complaints of pain or discomfort. Nurse on call notified and assessed resident over phone and gave staff the ok to get resident up. No pain or discomfort. Observed a small scratch on resident's left upper thigh area. Family notified of fall. Nurse also instructed staff to put a fall mat beside resident's bed when resident in bed." Signed certified staff D. NSA/HCS lacked documentation of use of a fall mat or other interventions to address resident #300's fall risk. 8/19/18 at 5:15 a.m. "When I arrived at 6:00 p.m. on 8/18/18 this writer was informed that resident had fallen. Staff had found resident on floor at 3:00 p.m. Resident was previously in recliner and slid out. Staff did inform on call nurse when happened." Signed certified staff K. 8/19/18 at 1:00 p.m. ". . Resident has a tennis ball size purple discoloration on right leg below the knee on right side. . ." Signed certified staff D. NSA/HCS lacked documentation of interventions to address continued fall risk On 10/2/18 at 11:10 a.m. observed certified staff D and E provide incontinent care to resident #300. Noted bed in low position with ½ side rail up on side of bed not against the wall. Observed	S5155		

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S5155	Continued From page 21 a pad alarm on bed. Resident slept through incontinent care provided. Certified staff E stated side rail was up on bed because resident had fallen out of bed. Certified staff E further stated resident is unable to bear any weight, assist with any care and is a full two-person transfer. Interview on 8/2/18 at 4:00 p.m. with licensed nurse G stated was not aware of reason for side rail on the bed. The NSA/HCS lacked a description of service related to the ½ side rail up, including monitoring the resident's ability to use it safely, and the safety of the device to address the risk for entrapment. For resident #300 the operator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services to meet the needs of the resident related to intervention to address fall risk and use of a side rail.	S5155		
S5161 SS=E	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility identified a census of 9 residents. The sample included 3 residents. Based on	S5161		

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record review, interview, and observations for 3 (#100, #200. #300) of 3 residents sampled, the operator failed to ensure the Negotiated Service Agreement (NSA) contained a description of Health Care Services (HCS) to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan.

Findings included:

- Record review for resident #100 on 10/2/18 at 10:20 a.m. revealed an admit date of 2/13/16 with diagnoses of dementia with behaviors, anxiety, and hypertension.

The functional capacity screen dated 2/22/18 recorded resident required supervision with dressing, toileting, transfer, walking/mobility, bladder incontinence, physical assistance with bathing, eating, experienced short-term memory loss, memory recall, long term memory loss, decision making, hard of hearing, impaired decision making, and falls/unsteadiness.

The NSA/HCS dated 2/12/18 recorded resident required one to two staff assistance with bathing due to resident being resistive with care and required physical assistance with dressing. Staff to supervise resident, assist with toileting and ambulation. Bed alarm to be in place to alert staff to resident needing assistance.

(The NSA/HCS lacked documentation that indicated resident required the use of a walker when ambulating.)

History and physical dated 8/12/18 recorded injury from fall: broken nose with nasal laceration and C1 fracture.

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S5161	Continued From page 23 The nurses notes recorded the following: 6/12/18 at 10:15 a.m. This nurse notified that resident was on floor in room. I went to room to find resident sitting on bedroom floor on blanket next to bed. Fall was witnessed by roommate who stated resident rolled out of bed. No injuries or discomfort noted. Resident put back to bed. Signed licensed nurse J. 8/12/18 at 5:45 a.m. "Resident got up in middle of the night and wandered to the living room. Staff went to tell resident it was the middle of the night and started to walk (him/her) to room; staff turned to open door, heard (resident) stumble and attempted to catch (him/her). Resident fell and hit face on the floor. The on-call nurse was called and informed staff to notify family and if they did not answer to call 911. Family did not answer so we called 911 paramedics came and got resident and left around 2:30 a.m. As of 6:20 a.m. family member and resident still at hospital." Signed certified staff K. 8/13/18 at 7:40 a.m. "Received multiple calls on 8/12/18 early morning. Informed of resident falling with facial injuries. Instructed staff to try and call family and 911. Hospital called with questions concerning when resident had tetanus shot and through resident would be returning shortly. Approximately 4:30 a.m. received another call from hospital stating resident had cervical fracture and damage to nose, was going to be transported to another hospital." Signed licensed nurse B. 8/13/18 at 9:00 p.m. "Resident returned to facility at 9:15 p.m. via private auto. Diagnosis: Acute nondisplaced fracture along left posterior arch of C1 and cervical spondylosis. Follow up	S5161		

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appointment in one week with Ears/Nose/Throat (ENT) doctor." Signed licensed nurse C.

8/14/18 at 5:50 a.m. Resident has to have help when up walking around, very unsteady and wobbly. When taken to restroom required physical assist. When resident would get up was assisted by one to two staff multiple times throughout the night. Resident keeps picking at sore on nose and poking (his/her) face. Resident's face is puffy, purple, and red. Signed certified staff K.

8/14/18 at 7:30 a.m. Arrived at facility, resident sitting at side of bed with caregiver. Sponge bath given with resident requiring assistance. Face is swollen with both eyes and most of face being bruised. Laceration on nose approximately 1 - 1 1/2 inches long with one steri-strip remaining in place. Area scabbed over. Resident reported to have difficulty with ambulation this morning with body wanting to lean backwards causing unsteadiness. Ambulate with staff assist to dining room. Signed licensed nurse B.

8/14/18 at 8:35 a.m. called medical care provider and received orders to resume previous medications prior to hospitalization. Received new order for Occupational and Physical therapy (OT/PT) evaluation and treat due to fall/unsteady gait. Family notified and discussed therapy order. Family voiced they realize resident is a fall risk but wanted (resident) to continue to do what (he/she) enjoyed. Family member stated (he/she) knew resident has refused to use a walker in the past. Signed licensed nurse B.

8/15/18 at 1:15 p.m. PT here working with resident upon my arrival at 11:30 a.m. and spoke to resident about using the walker. OT here to

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S5161	Continued From page 25 work with resident. Signed licensed nurse B. 8/17/18 at 8:00 p.m. "Came around the corner into the kitchen and saw resident walking from kitchen into the dining room. Right when caregiver got close to resident, (he/she) lost balance falling to the floor landing on right side at 6:25 p.m. On call nurse notified at 6:45 p.m. Family notified of fall." Signed certified staff L. (The record lacked documentation of an assessment performed by a licensed nurse and the name of the licensed nurse responsible for the implementation and supervision of the HCS. 8/18/18 at 2:00 p.m. Resident spent most of morning sleeping and had been pleasant with staff. Signed certified staff M. 8/19/18 at 5:00 a.m. "Resident has been in bed most of the evening and night, has not been feeling good, and would not specify what was wrong. Resident has been very sleepy and required physical assistance with walking all night." No complaint of pain. Signed certified staff K. 8/19/18 at 1:10 p.m. Resident up this morning and would not stay and eat breakfast but kept going back to bed and then get up a few minutes later and eat a few bites. Resident repeated this 3 times during meal. Staff followed resident each time. Resident was helped to the living room and very unsteady. Resident very concerned about family and wandering where they are. Staff assisted resident to bed and informed family would be here this weekend. Signed certified staff E. 8/20/18 at 5:30 a.m. Resident was up for a little	S5161		

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(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
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while and went to bed around 7:00 p.m. Resident has been coughing, sneezing, and has a runny nose. Worried about family and assisted to the bathroom. Resident assisted when up during the night. blood pressure (B/P) 115/61, pulse (P) 74, Temp 99.4, respiration (R) 19. Signed certified staff E.

(Record lacked documentation of nurse being notified for condition change and the name of the licensed nurse responsible for the implementation and supervision for HCS.)

8/20/18 at 8:15 a.m. Resident required stand by assistance when aware resident up or wanting to get up. Showed unsteadiness on feet several times this morning. Medical care provider notified of non-injury fall on 8/17/18 in evening. No new orders at this time. Signed licensed nurse B.

8/20/18 at 5:10 p.m. Medical care provider here to see resident. No new orders. Signed licensed nurse B.

9/28/18 at 1:30 p.m. This employee was opening medication cabinet and other employee was at the trash can dumping plates. Resident was handed a cup caked to eat just moments before and while staff was doing above task the staff by trash can heard a thud and found resident lying on back in doorway. Both employees went to resident and observed blood coming from the back of resident's head. Nurse on call notified. Nurse instructed staff to call 911 and apply pressure with rag until EMS arrived. EMS arrived and took resident to hospital. Family notified of fall. Signed certified staff E.

9/28/18 at 3:02 p.m. this nurse arrived as EMS was getting ready to leave and transported to

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hospital. Family not able to go to hospital so I went to hospital emergency room. Cat Scan was pending when family arrived, and I came back to facility to get report. Signed licensed nurse A.

9/28/18 at 4:45 p.m. Resident returned to facility via private auto with family. Alert to self. Received 6 staples to back of head. Vital signs B/P 120/93, P 78, R 16, T 98.2. Follow up for removal of staples in seven to fourteen days. Signed licensed nurse C.

9/29/18 at 1:27 p.m. resident up this morning and complained of a head ache. Nurse on call notified and PRN medication administered. Staff assisted resident to bathroom a few times and back to bed. Resident slept until lunch time. Signed certified staff E.

9/29/18 (no time) Resident sleeping in bed and observed laceration to head. Still oozing some blood. Appears to have taken a couple layers of skin approximately two inches in diameter around laceration. No swelling noted. Signed licensed nurse A.

9/30/18 at 6:30 a.m. Resident had a good night but very sleepy. Staff assisted to bathroom all night. When resident has been up staff has been beside resident. Signed certified staff K.

On 10/2/18 at 12:25 p.m. Observed resident in bed. Certified staff D assisted resident up to toilet. Observed 6 staples in occipital area on back of head. Dried blood noted around area. Resident ambulated with walker and assistance of certified staff D. At 12:35 p.m. resident attempted to put walker up and ambulate without it from dining room table. At 12:40 p.m. observed resident get up from chair by self and ambulate

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from dining room table to kitchen area without walker.

Interview on 10/2/18 at 4:00 p.m. with licensed nurse G stated licensed nurse A informed him/her he/she notified the Department of the fall with injury.

The record lacked a description of HCS to be provided and name of licensed nurse responsible for the implementation and supervision of the plan.

- Record review for resident #200 revealed an admit date of 10/20/14 with diagnoses of dementia, Parkinson's disease, hypertension, and cerebral vascular accident.

The functional capacity screen dated 10/5/17 recorded resident required physical assistance with eating, unable to assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired hearing, vision, and decision making. Resident has not experienced falls/unsteadiness.

The negotiated service agreement/health care service plan (NSA/HCS) dated 10/5/17 record resident required mechanically soft diet and staff to assist with feeding resident. Hospice staff to provide two showers a week and facility staff will provide showers as needed. Resident requires complete care for showers. Facility staff will provide complete care for toileting process, dressing, undressing, assistance with transfers, use hoyer lift with two staff for transfers, and one staff can push resident when in high back chair. Resident is hard of hearing and communication

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can be difficult. Staff will provide a visual check every four hours, check, change, and reposition at midnight and 4:00 a.m. per family request.

The nurses notes recorded:
8/28/18 at 2:20 p.m. This morning when helping resident to get up for the day staff noticed a large dark purple spot on resident's right shin. Staff unaware of what caused it and nurse on call notified. Resident did not complain of pain in right shin area. Resident did complain of mouth pain when eating. On call nurse instructed to give Tylenol 650 milligrams (MG) for pain. Signed certified staff E.

9/13/18 at 10:10 a.m. "Received call approximately at 1:00 a.m. reporting staff heard resident bed alarm. Upon entering bedroom, resident was found in a sitting position on fall mat with back resting against bed. Staff reported resident denied pain and instructed staff to get resident up and back to bed and obtain vital signs. Unable to locate vital signs this morning. Checked on resident and now noted to have approximately 5-inch bruising above right ankle and going upwards. When asked resident if trying to get up, resident nodded head yes and asked if ok, resident nodded yes. Medical care provider notified and no new orders". Signed licensed nurse C.

Record lacked follow up assessment of bruise and HCS to be provided and further lacked the name of licensed nurse responsible for the implementation and supervision of HCS.

- Record review for resident #300 revealed an

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admit date of 3/17/15 with diagnoses of Lewy body dementia and osteoporosis.

The functional capacity screen dated 3/17/18 recorded resident unable to assist with bathing dressing, toileting, transfer, walking/mobility, eating, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, socially disruptive inappropriate behaviors, and falls/unsteadiness.

The NSA/HCS dated 3/17/18 recorded resident on pureed diet and fed by staff and staff to offer supplemental drink if resident eats less than 50% of meal. Resident on hospice . . Resident is incontinent and required total care. Staff to check every two hours, change and provide peri-care each time. Resident required total assistance with dressing/undressing, is non-ambulatory with broda chair. Staff to ensure resident is propelled to needed area. Keep pummel cushion in broda chair. Resident has hospital bed and ½ side rail provided by hospice. Bed alarm in place to alert staff of potential need for assistances.

The nurses notes record the following:

8/11/18 at 10:33 a.m., "Resident's bed alarm was sounding and staff immediately went to resident's room. When staff entered the room, resident was on the floor next to bed lying down. Resident had no complaints of pain or discomfort. Nurse on call notified and assessed resident over phone and gave staff the ok to get resident up. No pain or discomfort. Observed a small scratch on resident's left upper thigh area. Family notified of fall. Nurse also instructed staff to put a fall mat beside resident's bed when resident in bed." Signed certified staff D.

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S5161	Continued From page 31 Record lacked documentation of assessment by a licensed nurse, HCS to be provided and name of licensed nurse responsible for implementation and supervision of the plan. 8/13/18 at 5:30 a.m. "Resident was in bed when I got here. Around 6:30 p.m. staff went in to change resident and (his/her) legs were hanging out of bed. Staff put legs back in bed and when moved legs (he/she) let out a loud scream. On call nurse notified and told staff to administer morphine .5 cubic centimeters (CC's). About 1:00 a.m. resident calmed down." Signed certified staff K. Record lacked documentation of assessment by a licensed nurse, HCS to be provided, named of licensed nurse responsible for implementation and supervision of the plan. 8/19/18 at 5:15 a.m. "When I arrived at 6:00 p.m. on 8/18/18 this writer was informed that resident had fallen. Staff had found resident on floor at 3:00 p.m. Resident was previously in recliner and slid out. Staff did inform on call nurse when happened." Signed certified staff K. 8/19/18 at 1:00 p.m. "Resident has been sleeping all day with no complaints of pain. Resident has a tennis ball size purple discoloration on right leg below the knee on right side. Resident's family called and informed of the fall and the purple discoloration at 12:47 p.m." Signed certified staff D. 8/20/18 at 8:10 a.m. "Resident remains in bed sleeping. Checked resident 's right knee. Noted light reddened/bruising area on outer right knee. Medical care provider notified. No new orders."	S5161		

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S5161	Continued From page 32 Signed licensed nurse B. Record lacked documentation of an assessment of the resident until 2 days after the fall, lacked a description of HCS to be proivded, name of licensed nurse responsbile for implementation of HCS and supervision of the plan.	S5161		
S5171 SS=E	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility identified a census of 9 residents. The sample included 3 residents. Based on record review, interview, and observations for 3 (#100, #200. #300) of 3 residents sampled, the operator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #100 on 10/2/18 at 10:20 a.m. revealed an admit date of 2/13/16 with diagnoses of dementia with behaviors, anxiety, and hypertension. The functional capacity screen (FCS) dated 2/22/18 recorded resident required supervision with dressing, toileting, transfer, walking/mobility, bladder incontinence, physical assistance with	S5171		

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bathing, eating, experienced short-term memory loss, memory recall, long term memory loss, decision making, hard of hearing, impaired decision making, and falls/unsteadiness.

The negotiated service agreement/health care service plan (NSA/HCS) dated 2/12/18 recorded resident required "one to two staff assist with bathing due to resident being resistive with care and required physical assistance with dressing. Staff to supervise resident and assist with toileting and ambulation. Bed alarm to be in place to alert staff to resident needing assistance."

The NSA/HCS lacked documentation that indicated resident required the use of a walker when ambulating.

History and physical dated 8/12/18 recorded injury from fall: broken nose with nasal laceration and C1 fracture.

The nurses notes recorded the following:

8/17/18 at 8:00 p.m. "Came around the corner into the kitchen and saw resident walking from kitchen into the dining room. Right when caregiver got close to resident, (he/she) lost balance falling to the floor landing on right side at 6:25 p.m. On call nurse notified at 6:45 p.m. Family notified of fall." Signed certified staff L.

The record lacked documentation of instructions by the licensed nurse at the time of the fall or a follow up assessment performed by a licensed nurse.

8/18/18 at 2:00 p.m. "Resident spent most of morning sleeping and had been pleasant with

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staff." Signed certified staff M.

8/19/18 at 5:00 a.m. "Resident has been in bed most of the evening and night, has not been feeling good, and would not specify what was wrong. Resident has been very sleepy and required physical assistance with walking all night." No complaint of pain. Signed certified staff K.

8/19/18 at 1:10 p.m. "Resident up this morning and would not stay and eat breakfast but kept going back to bed and then get up a few minutes later and eat a few bites. Resident repeated this 3 times during meal. Staff followed resident each time. Resident was helped to the living room and very unsteady. . . " Signed certified staff E.

Record lacked documentation of notification of the nurse of resident's change in condition or follow up assessment by the licensed nurse following the fall on 8/17/18.

8/20/18 at 5:30 a.m. "Resident was up for a little while and went to bed around 7:00 p.m. Resident has been coughing, sneezing, and has a runny nose. Worried about family and assisted to the bathroom. Resident assisted when up during the night. blood pressure (B/P) 115/61, pulse (P) 74, Temp 99.4, respiration (R) 19. Signed certified staff E.

8/20/18 at 8:15 a.m. Resident required stand by assistance when aware resident up or wanting to get up. Showed unsteadiness on feet several times this morning. Medical care provider notified of non-injury fall on 8/17/18 in evening. No new orders at this time. Signed licensed nurse B.

For resident #100, the operator failed to ensure

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all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice when licensed nurses failed assess the resident and provide direction to certified staff following resident fall and change in condition for 3 days.

Record review for resident #200 revealed an admit date of 10/20/14 with diagnoses of dementia, Parkinson's disease, hypertension, and cerebral vascular accident.

The functional capacity screen dated 10/5/17 recorded resident required physical assistance with eating, unable to assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired hearing, vision, and decision making. Resident has not experienced falls/unsteadiness.

The negotiated service agreement/health care service plan (NSA/HCS) dated 10/5/17 record resident required mechanically soft diet and staff to assist with feeding resident. Hospice staff to provide two showers a week and facility staff will provide showers as needed. Resident requires complete care for showers. Facility staff will provide complete care for toileting process, dressing, undressing, assistance with transfers, use hoyer lift with two staff for transfers, and one staff can push resident when in high back chair. Resident is hard of hearing and communication can be difficult. Staff will provide a visual check every four hours, check, change, and reposition at midnight and 4:00 a.m. per family request.

The nurses notes recorded:

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S5171	Continued From page 36 8/28/18 at 2:20 p.m. This morning when helping resident to get up for the day staff noticed a large dark purple spot on resident's right shin. Staff unaware of what caused it and nurse on call notified. Resident did not complain of pain in right shin area. Resident did complain of mouth pain when eating. On call nurse instructed to give Tylenol 650 milligrams (MG) for pain. Signed certified staff E. Record lacked documentation of follow up assessment by licensed nurse 9/13/18 at 10:10 a.m. "Received call approximately at 1:00 a.m. reporting staff heard resident bed alarm. Upon entering bedroom, resident was found in a sitting position on fall mat with back resting against bed. Staff reported resident denied pain and instructed staff to get resident up and back to bed and obtain vital signs. Unable to locate vital signs this morning. Checked on resident and now noted to have approximately 5-inch bruising above right ankle and going upwards. When asked resident if trying to get up, resident nodded head yes and asked if ok, resident nodded yes. Medical care provider notified and no new orders". Signed licensed nurse C. Record lacked follow up assessment bruise. For resident #200, the operator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice when licensed nurses failed assess resident following report of a bruise to the shin and complaint of mouth pain and further failed to conduct follow up assessment of a bruise noted after a fall.	S5171		

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- Record review for resident #300 revealed an admit date of 3/17/15 with diagnoses of Lewy body dementia and osteoporosis.

The functional capacity screen dated 3/17/18 recorded resident unable to assist with bathing dressing, toileting, transfer, walking/mobility, eating, bladder incontinence, experienced short-term memory loss, memory recall, long term memory loss, decision making, impaired decision making, socially disruptive inappropriate behaviors, and falls/unsteadiness.

The NSA/HCS dated 3/17/18 recorded resident on pureed diet and fed by staff and staff to offer supplemental drink is resident eats less than 50% of meal. Resident on hospice . . Resident is incontinent and required total care. Staff to check every two hours, change and provide peri-care each time. Resident required total assistance with dressing/undressing, is non-ambulatory with broda chair. Staff to ensure resident is propelled to needed area. Keep pummel cushion in broda chair. Resident has hospital bed and ½ side rail provided by hospice. Bed alarm in place to alert staff of potential need for assistances.

The nurses notes record the following:

8/11/18 at 10:33 a.m., "Resident's bed alarm was sounding and staff immediately went to resident's room. When staff entered the room, resident was on the floor next to bed lying down. Resident had no complaints of pain or discomfort. Nurse on call notified and assessed resident over phone and gave staff the ok to get resident up. No pain or discomfort. Observed a small scratch on resident's left upper thigh area. Family notified of

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fall. Nurse also instructed staff to put a fall mat beside resident's bed when resident in bed." Signed certified staff D.

Record lacked documentation of assessment by a licensed nurse.

8/13/18 at 5:30 a.m. "Resident was in bed when I got here. Around 6:30 p.m. staff went in to change resident and (his/her) legs were hanging out of bed. Staff put legs back in bed and when moved legs (he/she) let out a loud scream. On call nurse notified and told staff to administer morphine .5 cubic centimeters (CC's). About 1:00 a.m. resident calmed down." Signed certified staff K.

Record lacked documentation of assessment by a licensed nurse.

8/19/18 at 5:15 a.m. "When I arrived at 6:00 p.m. on 8/18/18 this writer was informed that resident had fallen. Staff had found resident on floor at 3:00 p.m. Resident was previously in recliner and slid out. Staff did inform on call nurse when happened." Signed certified staff K.

8/19/18 at 1:00 p.m. "Resident has been sleeping all day with no complaints of pain. Resident has a tennis ball size purple discoloration on right leg below the knee on right side. Resident's family called and informed of the fall and the purple discoloration at 12:47 p.m." Signed certified staff D.

8/20/18 at 8:10 a.m. "Resident remains in bed sleeping. Checked resident 's right knee. Noted light reddened/bruising area on outer right knee. Medical care provider notified. No new orders." Signed licensed nurse B.

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COMFORTCARE HOMES OF OTTAWA, LLC	27 E ROCKWOOD DRIVE OTTAWA, KS 66067

(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
S5171	Continued From page 39 Record lacked documentation of an assessment of the resident until 2 days after the fall. For resident #300, the operator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice when licensed nurses failed assess resident following reports of falls and complaint of pain requiring narcotic pain medication.	S5171		
S5230 SS=E	26-42-207 (b)(5)(6) (c) Infection Control Policies (b)(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(c) The facility identified a census of 9 residents. The sample included 3 residents and 1 (F) of 5 personnel records reviewed. For 3 (#100, #200, #300) of 3 residents sampled and 1 (certified staff	S5230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B030013	A. BUILDING: _____ B. WING _____	10/08/2018

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S5230	Continued From page 40 F) of 5 personnel records reviewed, the operator failed to ensure the home's compliance with the Department's Tuberculosis (TB) guidelines for adult care homes by reference in K.A.R. 26-39-105. Findings included: - Record review for resident #100 on 10/2/18 revealed an admit date of 2/13/16. The record contained a TB questionnaire dated 3/20/17. - Record review for resident #200 on 10/2/18 revealed an admit date of 10/20/14. The record contained a TB questionnaire dated 10/19/16. - Record review for resident #300 on 10/2/18 revealed an admit date of 3/17/15. The record contained a TB questionnaire dated 3/31/17. Interview on 10/2/18 with licensed nurse G confirmed the records lacked documentation of annual TB skin test or TB questionnaire. - Personnel records reviewed on 10/2/18 at 2:30 p.m. with licensed nurse G revealed certified staff (F) hired on 7/19/18. The record lacked documentation of a two-step TB skin test. Interview on 10/2/18 at 3:30 p.m. with licensed nurse G stated and confirmed certified staff (F) lacked documentation of a two-step TB skin test. For 3 (#100, #200, #300) of 3 residents sampled and 1 (certified staff F) of 5 personnel records reviewed, the operator failed to ensure the home's compliance with the Department's TB guidelines for adult care homes by reference in K.A.R. 26-39-105.	S5230		