STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087153	A. BUILDING: _____ B. WING _____	R-C 08/21/2018

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

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 18-114 of the above home plus facility on 8/20/18 and 8/21/18.	{S 000}		
{S5105} SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(3) The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#1021) of 3 residents sampled, operator B failed to ensure the development of a written negotiated service agreement (NSA) based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative that included a description of services provided by an outside	{S5105}		

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

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{S5105}	Continued From page 1 resource and the party responsible for payment for the services. Findings included: - Record review for resident #1021 revealed an admission date of 7/2/18 with diagnosis of bipolar disorder. Functional capacity screen dated 7/2/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform medication and treatment management; was at risk for falls; exhibited inappropriate behaviors; and used a wheelchair for mobility. NSA dated 7/2/18 documented the name of a home health agency providing skilled nursing, physical therapy, and occupational therapy. The NSA lacked a description of the services provided and the party responsible for payment of the services. During a phone interview at 1:30 p.m. on 8/20/18, licensed nurse C stated he/she did not revise the resident's NSA to include a description of services provided by home health and the party responsible for payment of the services. Operator B failed to ensure the development of a written NSA based on resident #1021's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative that included a description of the services provided by an outside resource and the party responsible for payment for the services.	{S5105}		

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{S5155}	Continued From page 2	{S5155}		
{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 6 residents. The sample included 3 residents. Based on record review, observations, and interview for 2 (#1021 and #1022) of 3 residents sampled, operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #1021 revealed an admission date of 7/2/18 with diagnosis of bipolar disorder. Functional capacity screen dated 7/2/18 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; experienced	{S5155}		

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{S5155}	Continued From page 3	{S5155}		

impaired short-term memory, long-term memory, memory recall, and decision making; was at risk for falls; and exhibited socially inappropriate behaviors.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 7/2/18 did not describe resident's socially inappropriate behaviors with interventions to address management of the behaviors.

During time in the facility on 8/20/18, surveyor observed resident #1021 mobilize self in wheelchair forwards and backwards. When resident mobilized wheelchair backwards he/she appeared to not be aware of anything or anyone behind him/her. During lunch while certified staff D fed resident #1022, resident #1021 demanded certified staff D to stop feeding resident #1022 and take his/her blood pressure. Certified staff D explained to resident #1021 that he/she would take resident's blood pressure later. Resident #1021 interrupted operator B numerous times and operator B asked resident #1021 to please wait. Resident #1021 verbalized not wanting to wait. At 1:01 p.m. surveyor observed resident mobilize self in wheelchair to his/her room along with certified staff D. Surveyor heard certified staff D say to resident that he/she needed to take kitchen items resident had taken to room and that resident was hoarding facility items. Certified staff D took the items and walked out of room and resident began yelling.

NSA/HCSP documented resident utilized a "bed mobility rail." Resident's record lacked an assessment of the safety of the mobility device when being used by resident.

At 1:01 p.m. on 8/20/18, along with operator B,

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{S5155}	Continued From page 4	{S5155}		

observed a bed mobility device on the side of the resident's bed. Operator B stated he she secured the device to the resident's bed, so the device would not move when resident held on to it when transferring in and out of bed. When asked for the documented assessment of the safety of the bed mobility device and resident's ability to safely use the device, operator B stated he/she did not document an assessment. Operator B stated he/she would call (licensed nurse C) to ask if the nurse assessed and documented an assessment.

During a phone interview at 1:30 p.m. on 8/20/18, licensed nurse C stated he/she did not document his/her assessment of the bed mobility device and resident's ability to safely use the device. Licensed nurse C stated he/she did not revise the resident's NSA/HCSP to include behavior management interventions.

Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #1021 and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #1022 revealed an admission date of 6/7/14 with diagnoses of Alzheimer's type dementia and hypertension.

Functional capacity screen dated 5/26/18 indicated resident was unable to perform bathing, dressing, toileting, transferring, mobility, and eating; was incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and resident's communication was rarely or never understandable and rarely or never understood

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{S5155}	Continued From page 5 communication. Negotiated service agreement dated 5/26/18 documented resident to receive a therapeutic diet of pureed food/finger food. Health care service plan updated 3/20/18 documented pureed diet. At 12:11 p.m. on 8/20/18, surveyor observed resident #1022 sitting in wheelchair at table with a plate of food that included cooked cabbage with sausage that appeared to be ground, fruit cocktail, and cake. At 12:13 p.m. certified staff D began feeding resident and stated resident received a mechanical soft diet. Health care service plan documented certified staff to check the resident every 2 hours to determine need to provide incontinence care and to change resident's position every 2 hours to prevent skin breakdown. During time in the facility 8/20/18 from 9:50 a.m. until 1:45 p.m. surveyor observed resident sitting in a wheelchair in the dining room/living room area. Certified staff did not assist resident to shift weight or take resident to his/her room to provide incontinence care if needed. At 1:06 p.m. on 8/20/18, surveyor asked certified staff D if he/she was going to feed lunch to another resident (resident #1023) who had not had lunch. Certified staff D stated he/she needed to assist resident #1022 to bed before feeding resident (#1023). At 1:20 p.m. certified staff D began feeding lunch to resident #1023. Resident #1022 remained seated in wheelchair in dining room/living room area. Certified staff D stated the nurse instructed him/her to not lay resident #1022 in bed for 30 minutes after eating due to pocketing food in mouth.	{S5155}		

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{S5155}	Continued From page 6 At 1:23 p.m. on 8/20/18 resident #1022 remained seated in wheelchair. Surveyor informed operator B that resident #1022 had been in wheelchair since 9:50 a.m. without staff providing care as specified in the health care service plan. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #1022 and were in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
{S5195} SS=E	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 6 residents. The sample included 3 residents. Based on observation and interview for all residents, operator B failed to ensure facility staff stored all foods under safe and sanitary conditions. Findings included: - At 10:10 a.m. on 8/20/18 surveyor began observing food storage in the kitchen as follows:	{S5195}		

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{S5195}	Continued From page 7 In the refrigerator 2 partial packages of thinly sliced turkey with 1 package not sealed tightly and one package of smoked ham. The packages were not labeled with a date to indicate when each package was opened. Freezer held an open plastic partial package of fish sticks, a sealed plastic bag with fish sticks, plastic storage bag labeled "sausage 6" that held 6 frost covered sausage patties, and a partial 1-gallon container of Neapolitan ice cream. None of these packages were labeled with the date staff opened the package or container. A cabinet by the oven held an open can of mixed nuts with best by date of 1/21/18, jar of hazel nut spread with best by date of 7/7/17, and an open bag of gingersnap cookies without a date the package was opened. Open 72-ounce box of instant rice with top of box pulled back stored on shelf above oven. Cabinet to right of kitchen sink held an open carton of instant potatoes that was not securely closed. At 1:10 p.m. on 8/20/18, surveyor showed these food items to operator B who started securely packaging the food items. Operator B failed to ensure facility staff stored all foods under safe and sanitary conditions.	{S5195}		
{S5335} SS=E	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect	{S5335}		

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{S5335}	Continued From page 8 the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of 6 residents. The sample included 3 residents. Based on observation and record review for the safety of all residents, operator B failed to ensure cleaning supplies were not accessible to the cognitively impaired residents. Findings included: - At 9:57 a.m. on 8/20/18, surveyor observed an unlocked closet in the west hall by the washer and dryer. The closet stored liquid bleach, Clorox toilet bowl cleaner with open safety cap, Bona floor cleaner liquid, Fabuloso liquid cleaner with no cap on bottle, Comet powder, bed bug spray, dusting spray, WD 40 spray, and disinfectant wipes. The cabinet above the washer held a large box of dishwasher packets, OdoBan spray, and liquid laundry detergent. This cabinet had a child protective lock that was not locked and easily removed from the cabinet door handles. The resident roster indicated each of the 6 residents experienced impaired cognition. During time in the facility on 8/20/18, surveyor observed resident #1021 mobilize self in	{S5335}		

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{S5335}	Continued From page 9 wheelchair and resident #1024 and resident #1023 each able to ambulate without assistance. Resident #1020 was in the hospital, but record review revealed resident mobilized self in a wheelchair. During an interview at 1:10 p.m. on 8/201/18, operator B stated and confirmed closet to remain locked. Operator B failed to ensure cleaning supplies were not accessible to the cognitively impaired residents.	{S5335}		