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 _____	07/30/2018

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 resurvey with investigation of complaint #122095 of the above home plus facility on 7/19/18, 7/23/18, 7/25/18, 7/26/18, and 7/30/18.	S 000		
S 225 SS=E	26-39-102 (a) Admission Policy (a) Each licensee, administrator, or operator shall develop written admission policies regarding the admission of residents. The admission policy shall meet the following requirements: (1) The administrator or operator shall ensure the admission of only those individuals whose physical, mental, and psychosocial needs can be met within the accommodations and services available in the adult care home. (A) Each resident in a nursing facility or nursing facility for mental health shall be admitted under the care of a physician licensed to practice in Kansas. (B) The administrator or operator shall ensure that no children under the age of 16 are admitted to the adult care home. (C) The administrator or operator shall allow the admission of an individual in need of specialized services for mental illness to the adult care home only if accommodations and treatment that will assist that individual to achieve and maintain the highest practicable level of physical, mental, and psychosocial functioning are available. (2) Before admission, the administrator or operator, or the designee, shall inform the prospective resident or the resident ' s legal representative in writing of the rates and charges for the adult care home's services and of the resident's obligations regarding payment. This information shall include the refund policy of the adult care home.(3) At the time of admission, the administrator or operator, or the designee, shall	S 225		

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

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S 225	Continued From page 1 execute with the resident or the resident ' s legal representative a written agreement that describes in detail the services and goods the resident will receive and specifies the obligations that the resident has toward the adult care home. (4) An admission agreement shall not include a general waiver of liability for the health and safety of residents. (5) Each admission agreement shall be written in clear and unambiguous language and printed clearly in black type that is 12-point type or larger. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(a)(4) The facility reported a census of 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on record review and interview for 3 (#100, #200, and #300) of 3 residents sampled, operator B failed to ensure the admission agreement did not include a general waiver of liability for the health and safety of residents. Findings included: - Record reviews for residents #100, #200, and #300 revealed the following: Resident #100 admitted on 5/4/18 with diagnosis of Alzheimer's dementia. Resident #200 admitted on 6/13/18 with diagnosis of chronic obstructive pulmonary disease.	S 225		

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S 225	Continued From page 2 Resident #300 admitted on 7/2/18 with diagnosis of bipolar disorder. Each record contained a rental agreement signed by the resident or the resident's responsible party that included the following statement under the section titled "Injuries" of "The resident or responsible party hereby agrees to release and hold harmless Accord Senior Care, INC from any liability for injuries of any kind suffered by the resident while at Accord Senior Care, INC. The resident or responsible party further agrees to release and hold harmless Accord Senior Care, INC from any liability for injuries suffered by the resident while away from Accord Senior Care, INC." During an interview at 12:44 p.m. on 7/23/18, operator B stated and confirmed the statement released the facility from liability of injuries and/or harm to residents. For residents #100, #200, and #300, operator B failed to ensure the admission agreement did not include a general waiver of liability for the health and safety of residents.	S 225		
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.	S5028		

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S5028	Continued From page 3 (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: KAR 26-42-101(f)(3)(A)(B) The facility reported a census of 5 residents. The sample included 3 residents, 2 focus review residents, and review of 2 closed records. Based on record review and interview for 1 (#300) of 3 residents sampled, operator B failed to report an allegation of abuse to the department within 24 hours, failed to initiate an investigation, and failed to take immediate measures to prevent further potential abuse while an investigation was in progress. Based on record review, observation, and interview for 2 (#300 and #100) of 3 residents sampled, operator B failed to report an allegation of resident-to-resident abuse to the department	S5028		

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S5028	Continued From page 4 within 24 hours. Findings included: - Record review for resident #300 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 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 dated 7/2/18 did not describe resident's socially inappropriate behaviors with interventions to address management of the behaviors. The resident roster, completed by operator B on 7/19/18, indicated resident had experienced a fall within the last 6 months. Documentation by licensed nurse C in the wellness notes lacked information that resident experienced a fall. During an interview at 12:30 p.m. on 7/23/18 when asked if resident had fallen, licensed nurse C stated resident sat self on floor and called family members to report an employee has pushed him/her on floor. Licensed nurse C stated he/she did not witness resident sit self on floor. Operator B stated the allegation was not reported to the department or investigated. At 11:58 a.m. on 7/19/18, surveyor observed	S5028		

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S5028	Continued From page 5	S5028		

resident #300 sitting in a wheelchair at the dining table and residents #100 and #450 each sitting in a recliner with feet elevated. Residents #100, #300, and #450 were all in the same room. Resident #100 began to climb out of recliner without lowering the foot rest. Certified staff D was in the kitchen and could not see the residents. Surveyor asked certified staff D if resident #100 could ambulate without assistance. Certified staff D then came into the living/dining room and made sure resident #100 was steady while walking. Certified staff D remained in the area and resident #100 continued to walk independently. Resident #100 walked up behind resident #300 and picked up resident #300's cell phone that was sitting on the dining room table. Resident #300 quickly and firmly grabbed resident #100's wrist and held resident's hand down on the table with his/her left hand while making a fist and pulling right arm back. Resident #300 stated to resident #100 "You break my phone I will kill you." Certified staff D intervened and took cell phone from resident #100 and gave it to resident #300. Certified staff D attempted to calm resident #300 while operator B walked resident #100 away from the area.

Review of resident #100's record revealed an admission date of 5/4/18 with diagnosis of Alzheimer's disease. Functional capacity screen dated 5/4/18 indicated resident experienced impaired short-term memory, long-term memory, memory recall, and decision making and exhibited wandering behavior. Negotiated service agreement dated 5/4/18 documented resident required "Constant monitoring, always picking up items and moving stuff."

During an interview at 12:30 p.m. on 7/23/18, operator B stated he/she did not report to the

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S5028	Continued From page 6 department or investigate the resident-to-resident incident. On 7/24/18 the department received an intake from operator B as follows: Resident (#300), slight MR (mental retardation) Resident (#100), moderate dementia Date 7/19/18 about 11:45 AM A state surveyor reported (he/she) saw (resident #300) take a cell phone from (resident #100). During investigation it was found that (resident #100) took (resident #300's) cell phone and (resident #300) was taking it back. The nurse assessed the residents and no injury was found. (Resident #100) did not seem afraid of (resident #300). (Resident #300) does not have history of aggression or taking items away from others. (Resident #100) has history of picking up items that are not (his/her's), (he/she) had not picked up another resident's items until this incident. Intervention: (Resident #300) was educated to ask staff for help to get (his/her) items back from another resident. Staff were educated to assist and ask (resident #300) if (he/she) needs anything and to remind (him/her) they are there to help (him/her). Staff will continue to monitor (resident #100) and remind (him/her) to not pick up things that do not belong to (him/her).	S5028		

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S5028	Continued From page 7 Resident #300 alleged staff mistreated resident. Operator B failed to report to the department within 24 hours of the allegation, failed to investigate, and failed to take immediate measures to prevent further potential abuse while an investigation was in progress. Resident #300 and resident #100 were involved in an altercation. Operator B failed to report the incident to the department within 24 hours and failed to thoroughly investigate the incident.	S5028		
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)(3) The facility reported a census of 5 residents. The sample included 3 residents, 1 focus review	S5105		

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S5105	Continued From page 8	S5105		

resident, and review of 2 closed records. Based on record review and interview for 2 (#200 and #300) 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 the services provided by an outside resource and the party responsible for payment for the services.

Findings included:

- Record review for resident #200 revealed an admission date of 6/13/18 with diagnosis of chronic obstructive pulmonary disease.

Functional capacity screen dated 6/13/18 indicated resident required physical assistance with bathing, dressing, toileting, and transferring; was unable to ambulate or mobilize self in wheelchair; unable to perform management of medications and treatments; was frequently incontinent of urine; and was at risk for falls.

NSA dated 6/13/18 documented the name of a hospice as an outside provider. The NSA lacked a description of services provided by hospice and the party responsible for payment of hospice services.

During an interview at 9:55 a.m. on 7/25/18, operator B stated resident received hospice services of skilled nursing, home health aide, chaplain, social worker, and volunteer. Operator B stated and confirmed the NSA did not contain a description of the services each discipline provided to the resident and the party responsible for payment of hospice services.

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S5105	Continued From page 9 Operator B failed to ensure the development of a written NSA based on resident #200'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. - Record review for resident #300 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 an interview at 12:09 p.m. on 7/23/18, licensed nurse C stated a home health nurse worked with resident for behavior management and physical therapy and occupational therapy worked with resident on strengthening to improve functional status. During an interview at 10:11 a.m. on 7/25/18, operator B stated NSA did not describe the services provided by home health and did not include the party responsible for payment of the	S5105		

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S5105	Continued From page 10 services. Operator B failed to ensure the development of a written NSA based on resident #300'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		
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 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on record review, observations, and interview for 3 (#300, #100, and #200) of 3 residents sampled and 1 (#400) of 1 focus review resident, operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of each resident and were in accordance with the functional	S5155		

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S5155	Continued From page 11 capacity screening and the negotiated service agreement. Findings included: - Upon entrance to the facility at 9:00 a.m. on 7/19/18, surveyor met resident #300 sitting in a wheelchair in the living room. Resident introduced self, stated he/she had not lived here very long, and was moving to another facility. Tour of the facility began at 9:06 a.m. on 7/19/18 with certified staff D. While in the west end of the facility, surveyor heard someone hitting on something. Certified staff D stated it was resident (#300) who had emotional outbursts. Certified staff D went to check on resident #300 and then returned. Surveyor observed the room of resident #300. Resident had a twin-size bed with a mobility device on the side of the bed. Surveyor observed that the device was held in place by two metal pieces that slid between the mattress and the bedframe. The device was not securely attached to the bed and easily slid away from the mattress when pressure applied to the top of the device. Record review for resident #300 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 impaired short-term memory, long-term memory, memory recall, and decision making; was at risk for falls; and exhibited socially inappropriate	S5155		

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S5155	Continued From page 12 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. NSA/HCSP did not describe resident's use of the mobility device observed on resident's bed. Resident's record lacked an assessment of the safety of the mobility device when being used by resident. Wellness notes contained documentation by licensed nurse C as follows: 7/3/18 at 5:30 p.m. Resident with increasing behaviors of hitting staff, cussing, charging at people in wheelchair. Discussed with family and medical care provider. 7/4/18 Resident continues with behaviors and medications with short duration and effect. 7/5/18 Resident required PRN (as needed) medications due to continued behaviors. 7/7/18 Noted behaviors intensify with staff on duty. 7/7/18 at 3:00 p.m. Phone call to resident's durable power of attorney that behaviors are intensifying and intentional; discussed (resident) able to do more that (he/she) is willing but demands constant attention. (Operator B) also made aware. At 11:58 a.m. on 7/19/18, surveyor observed resident #300 sitting in a wheelchair at the dining table and residents #100 and #450 each sitting in a recliner with feet elevated. Residents #300,	S5155		

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S5155	Continued From page 13	S5155		

#100, and #450 were all in the same room. Resident #100 began to climb out of recliner without lowering the foot rest. Certified staff D was in the kitchen and could not see the residents. Surveyor asked certified staff D if resident #100 could ambulate without assistance. Certified staff D then came into the living/dining room and made sure resident #100 was steady while walking. Certified staff D remained in the area and resident #100 continued to walk independently. Resident #100 walked up behind resident #300 and picked up resident #300's cell phone that was sitting on the dining room table. Resident #300 quickly and firmly grabbed resident #100's wrist and held resident's hand down on the table with his/her left hand while making a fist and pulling right arm back. Resident #300 stated to resident #100 "You break my phone I will kill you." Certified staff D intervened and took cell phone from resident #100 and gave it to resident #300. Certified staff D attempted to calm resident #300 while operator B walked resident #100 away from the area.

During an interview at 12:09 p.m. on 7/23/18, licensed nurse C stated resident #300 was physically and verbally abusive to staff with resident wanting constant attention from staff. Licensed nurse C stated redirection did not manage resident's behaviors for long. Licensed nurse C stated resident had medication (for anxiety) ordered on an as needed basis. Licensed nurse C did not list any other interventions to manage resident's behavior. When asked for interventions to protect the safety of other residents, licensed nurse C stated resident would not abuse other residents. Licensed nurse C stated he/she did assess the safety of resident's bed mobility device but did not document the assessment. Licensed nurse C

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stated he/she was not aware the bed mobility device was not attached to the bedframe.

During an interview at 1:10 p.m. on 7/23/18, certified staff D stated he/she tried to manage resident's behaviors by redirecting resident, listening to resident talk, or let resident have time alone to calm down.

During an interview at 10:11 a.m. on 7/25/18 operator B reviewed the NSA/HCSP for resident #300 and stated each lacked intervention to manage resident's behaviors.

Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #300 and were in accordance with the functional capacity screening and the negotiated service agreement.

- During tour of the facility with certified staff D at 9:18 a.m. on 7/19/18 surveyor observed the room of resident #100 that certified staff D stated was shared with resident #400. After walking out of this room, surveyor observed a safety gate against the wall next to the door to the room of resident #200. Certified staff D stated the gate was used in the doorway to (resident #200's) room to keep
(resident #100) from wandering in that room. Certified staff D stated (resident #200) was blind and it upset resident when (resident #100) wandered into room.

Record review for resident #100 revealed an admission date of 5/4/18 with diagnosis of Alzheimer's disease.

Functional capacity screen dated 5/4/18 indicated

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resident was independent with transferring, walking, and eating; required supervision with bathing, dressing, and toileting; was unable to perform management of medications and treatments; experienced impaired short-term memory, long-term memory, memory recall, and decision making and exhibited wandering behavior.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 5/4/18 documented resident required "Constant monitoring, always picking up items and moving stuff." The NSA/HCSP did not address management of resident's wandering behavior and measures to keep resident safe. The record contained a form "Alzheimer's/dementia supplement to care plan" that documented possible interventions but none of these addressed management of resident #100's wandering behavior.

At 11:58 a.m. on 7/19/18, surveyor observed resident #300 sitting in a wheelchair at the dining table and residents #100 and #450 each sitting in a recliner with feet elevated. Residents #300, #100, and #450 were all in the same room. Resident #100 began to climb out of recliner without lowering the foot rest. Certified staff D was in the kitchen and could not see the residents. Surveyor asked certified staff D if resident #100 could ambulate without assistance. Certified staff D then came into the living/dining room and made sure resident #100 was steady while walking. Certified staff D remained in the area and resident #100 continued to walk independently. Resident #100 walked up behind resident #300 and picked up resident #300's cell phone that was sitting on the dining room table. Resident #300 quickly and firmly grabbed resident #100's wrist and held resident's hand

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down on the table with his/her left hand while making a fist and pulling right arm back. Resident #300 stated to resident #100 "You break my phone I will kill you." Certified staff D intervened and took cell phone from resident #100 and gave it to resident #300. Certified staff D attempted to calm resident #300 while operator B walked resident #100 away from the area.

At 3:34 p.m. on 7/19/18, surveyor observed resident #100's room with an attached bathroom. The vanity cabinet, accessible to resident, below the bathroom sink contained a partial bottle of Lysol spray disinfectant, a full bottle of Clorox toilet bowl cleaner, an open box of baking soda, denture cleaning tablets, and an unlabeled plastic specimen cup with pink liquid. Surveyor observed a 3/4 full 24-ounce bottle of Mr. Clean multi-purpose cleaner in a drawer in the vanity cabinet.

During an interview at 12:44 p.m. on 7/23/18, licensed nurse C stated the intervention of constant monitoring was no longer in effect. Per operator B resident walked around picking up items when first admitted and no longer picked up items as he/she wandered. Licensed nurse C confirmed the NSA/HCSP lacked interventions to address wandering behavior and resident's safety.

Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #100 and were in accordance with the functional capacity screening and the negotiated service agreement.

- During tour of the facility with certified staff D at 9:18 a.m. on 7/19/18 surveyor observed a safety

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gate against the wall next to the door to the room of resident #200. Certified staff D stated the gate was used in the doorway to (resident #200's) room to keep resident #100) from wandering in that room. Certified staff D stated (resident #200) was blind and it upset resident when (resident #100) wandered into room. Resident #200 observed in bed talking on phone.

Record review for resident #200 revealed an admission date of 6/13/18 with diagnosis of chronic obstructive pulmonary disease.

Functional capacity screen dated 6/13/18 indicated resident required physical assistance with bathing, dressing, toileting, and transferring; was unable to ambulate or mobilize self in wheelchair; required supervision with eating; unable to perform management of medications and treatments; was frequently incontinent of urine; was not cognitively impaired; vision impaired; and was at risk for falls.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 6/13/18 lacked interventions to address resident's impaired vision and measures to monitor that other residents did not enter this resident's room.

Wellness notes contained documentation by licensed nurse J as follows:

7/14/18 at 12:00 p.m. that resident had been "escalating all morning." Operator (B) called a behavioral health unit and they had no openings and another behavioral health unit declined to admit resident. Resident not compliant with care. Hospice nurse was called and came to assess resident. Resident called police department. Operator (B) talked with a police officer and it was

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S5155	Continued From page 18 determined to call emergency medical services and resident was transferred to hospital. 7/14/18 at 6:10 p.m. Resident was returned from hospital by emergency medical services. Resident yelling and argumentative, adamant about smoking a cigarette even after nurse and certified staff explained this was a non-smoking facility. Staff walked away from resident to try to calm resident. Topical Ativan (antianxiety medication) given at 6:15 p.m. 7/16/18 at 9:45 p., resident having extreme behaviors yelling, hitting, and trying to bite. Medicated as ordered. NSA/HCSP lacked interventions to manage resident's behaviors and anxiety. During an interview at 1:05 p.m. on 7/23/18, when asked what interventions were implemented to manage resident's behaviors and anxiety, licensed nurse C stated, "Nicotine patch and Ativan." Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #200 and were in accordance with the functional capacity screening and the negotiated service agreement. - During tour of the facility with certified staff D at 9:18 a.m. on 7/19/18 surveyor observed the room of resident #400. Certified staff D stated resident was currently out of the facility due to admission to a "behavior unit." Record review for resident #400 revealed an admission date of 6/1/18 with diagnoses of	S5155		

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S5155	Continued From page 19 post-traumatic stress disorder, schizoaffective disorder, bipolar, and dementia. Functional capacity screen dated 6/1/18 indicated resident was independent with dressing, transferring, mobility and eating; required supervision with bathing and toileting; was unable to perform management of medications and treatments; and experienced impaired decision making. Wellness notes contained documentation by licensed nurse C as follows: 6/1/18 at 5:00 p.m. admission note of resident awake and alert to person, place, and situation/time. Ambulates with a steady gait. History and physical reviewed. Medications reviewed/reconciled. Assessments completed. Next entry dated 7/1/18 of no new behaviors noted. Does spend time in room and chooses not to socialize. No change in medications. The resident's record lacked documentation to indicate reason resident required hospitalization for behavior management or documentation that resident was admitted to a behavioral health unit. The record lacked an order from the resident's medical care provider to transfer resident to the behavioral health unit. During an interview at 1:22 p.m. on 7/19/18, operator B stated resident was admitted to behavioral health unit on 7/11/18 due to secluding self in room and refusing care. Operator B stated someone from the behavioral health unit came to assess resident and wanted resident admitted for medication adjustment.	S5155		

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S5155	Continued From page 20 At 11:48 a.m. on 7/23/18, licensed nurse C stated he/she called the contact person at the behavioral health unit due to resident isolating self and not adjusting to the facility. Licensed nurse C stated he/she would walk into resident's room and resident "would look at me like (resident) was going to kill me." Surveyor informed licensed nurse C that the record lacked documentation of need to be admitted to behavioral health unit and the date of admission. Licensed nurse C stated he/she had an order dated 7/9/18 for transfer from the facility and admission to the behavioral health unit. Review of the resident's negotiated service agreement/health care service plan dated 6/1/18 revealed the lack of interventions to address resident's isolation and refusal of care. Operator B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service that met the needs of resident #400 and were in accordance with the functional capacity screening and the negotiated service agreement.	S5155		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening	S5192		

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S5192	Continued From page 21 with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on interview, observation, and record review for all residents, operator B failed to ensure food was prepared using safe methods and served at the proper temperature. Findings included: - At 10:37 a.m. on 7/19/18, certified staff D stated he/she measured the temperature of hot foods to ensure a cooked temperature of at least 140 degrees Fahrenheit. Certified staff D stated he/she did not record food temperature readings. Operator B also stated employees did not record food temperature readings. Surveyor asked certified staff D for the facility's food thermometer. Operator B and certified staff D looked for the food thermometer. Certified staff D stated he/she did not use the thermometer for breakfast since residents had cold cereal with milk and he/she did not measure temperature of cold foods before serving to residents. Certified staff D found the thermometer on the kitchen countertop behind the coffee pot. Certified staff D stated the thermometer did not work.	S5192		

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S5192	Continued From page 22 Record review for residents #100, #200, #300, and #400 revealed each resident received meals prepared by facility staff. At 12:10 p.m. on 7/19/18, observed residents #300, #100, and #450 eating burrito casserole, corn, and canned peach slices at the dining table. Review of the facility's policy and procedure manual on 7/23/18 revealed "Food Services Sanitation" policy and procedure with purpose identified as "to set forth guidelines for the safe and sanitary handling and preparations of foods prepared for the residents by dining services." The policy and procedure did not include measuring and recording temperature of foods. For all residents, operator B failed to ensure food was prepared using safe methods and served at the proper temperature.	S5192		
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 5 residents. The sample included 3 residents, 1 focus review	S5195		

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resident, and review of 2 closed records. Based on observations, interviews, and record reviews for all residents, operator B failed to ensure facility staff stored all foods under safe and sanitary conditions.

Findings included:

- At 9:25 a.m. on 7/19/18, surveyor began observing food storage in the kitchen with numerous food items improperly stored that included foods opened without an open date marked on the food packaging, foods in opened and unsealed packaging, outdated items, and packages/containers of unidentified food items.

Some of the food items in the refrigerator included:

3 raw hamburger patties in an undated plastic bag to identify when the meat was placed in the refrigerator.
Pizza slices in foil with the pizza not securely covered by the foil.
Open brown paper sack with a resident's name written on the sack. The sack held 2 pieces of fried chicken with a store label dated 7/13/18. A plastic container with store label of mashed potatoes 7/13/18 labeled with the same resident's name.
An opened 40-ounce bag of shaved ham without a date to identify when the package was opened.
A partial tomato in a plastic bag. Mold growing on tomato.
An individual applesauce container with foil lid partially opened.

Some of the items in the freezer included:

A bag of fish sticks in the original package. The

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top of the bag opened and not tightly closed.
Plastic storage bag without a label to identify contents (appeared to be chopped peppers) and no date to indicate when food was placed in the storage bag. Food item covered with frost.
A vacuum sealed package of what appeared to be fish. Packaging not labeled or dated.

Some of the dry food items included:

72-ounce box of instant rice with top of box opened and folded back. This box sat on an open shelf above the oven.
A jar of hazelnut spread with best by date of 7/7/17.
Partial can of mixed nuts with best by date of 1/21/18. Can was not labeled with the date opened.
Package of 5 hot dog buns covered with mold.
Hot dog package labeled with best by date of 6/18/18.
3 slices of white bread in original package with best by date of 5/29/18.
Open bag of marshmallows without top of bag tightly closed.
Container of baking cocoa with best by date of 11/26/15.

A 10:30 a.m. on 7/19/18, surveyor informed operator B the food items outdated and improperly stored. Operator B began throwing out food items. Also, at this time surveyor observed documentation of the kitchen refrigerator and freezer temperature. Operator B stated staff members were to monitor and record the kitchen refrigerator/freezer temperatures one time a week. At 9:06 a.m. on 7/19/18, surveyor observed food items stored in a refrigerator, an upright freezer, and a chest freezer located in the garage. Surveyor asked operator B for

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S5195	Continued From page 25 documentation of the temperatures readings for the refrigerator and freezers located in the garage. Operator B stated he/she monitored those temperatures on a weekly basis but did not record the temperature readings. Record review for residents #100, #200, #300, and #400 revealed each resident received meals prepared by facility staff. At 12:10 p.m. on 7/19/18, observed residents #300, #100, and #450 eating burrito casserole, corn, and canned peach slices at the dining table. On 7/23/18 at 9:28 a.m., surveyor asked for the facility's policy and procedure manual. Surveyor could not find a policy and procedure for food storage. At 10:59 a.m. on 7/23/18, operator B stated he/she did not have a written policy and procedure for food storage. For all residents, operator B failed to ensure facility staff stored all foods under safe and sanitary conditions.	S5195		
S5215 SS=E	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents;	S5215		

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S5215	Continued From page 26 and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on interview for all residents, operator B failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the emergency management plan with residents. Findings included: - At 10:50 a.m. on 7/19/18, when asked for documentation of the quarterly review of the emergency management plan with residents, operator B stated he/she did not have documentation of any reviews. Operator B stated that he/she did not review the facility's emergency management plan with residents since each resident's case manager reviewed an emergency plan every 6 months with resident. Operator B failed to ensure disaster and emergency preparedness by ensuring the performance of a quarterly review of the emergency management plan with residents.	S5215		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents	S5251		

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S5251	Continued From page 27 (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on record review, observations, and interviews for 1 (#300) of 3 residents sampled and 1 (#400) of 1 focus review resident, operator B failed to ensure each residents record contained documentation of all incidents, symptoms, and other indications of illness including the date, the time of occurrence, the action taken, and the results of the action. Findings included: - Record review for resident #300 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 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	S5251		

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	B087153	A. BUILDING: _____ B. WING _____	07/30/2018

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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S5251	Continued From page 28 plan dated 7/2/18 did not describe resident's socially inappropriate behaviors with interventions to address management of the behaviors. Wellness notes contained documentation by licensed nurse C as follows: 7/3/18 at 5:30 p.m. Resident with increasing behaviors of hitting staff, cussing, charging at people in wheelchair. Discussed with family and medical care provider. The entry lacked documentation of interventions and results of the interventions. 7/4/18 Resident continues with behaviors and medications with short duration and effect. The entry lacked a description of resident's behaviors. 7/5/18 Resident required PRN (as needed) medications due to continued behaviors. The entry lacked a description of the behaviors, action taken, and results of action. 7/7/18 Noted behaviors intensify with staff on duty. The entry lacked a description of the behaviors, action taken, and results of action. 7/7/18 at 3:00 p.m. Phone call to resident's durable power of attorney that behaviors are intensifying and intentional; discussed (resident) able to do more that (he/she) is willing but demands constant attention. (Operator B) also made aware. The entry lacked a description of the behaviors, action taken, and results of action. The resident roster, completed by operator B on 7/19/18, indicated resident had experienced a fall within the last 6 months. Documentation by licensed nurse C in the wellness notes lacked information that resident experienced a fall.	S5251		

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S5251	Continued From page 29 During an interview at 12:30 p.m. on 7/23/18 when asked if resident had fallen, licensed nurse C stated resident sat self on floor and called family members to report an employee has pushed him/her on floor. Licensed nurse C stated he/she did not witness resident sit self on floor. Operator B failed to ensure resident #300's record contained documentation of all incidents including the date, the time of occurrence, the action taken, and the results of the action. - During tour of the facility with certified staff D at 9:18 a.m. on 7/19/18 surveyor observed the room of resident #400. Certified staff D stated resident was currently out of the facility due to admission to a "behavior unit." Record review for resident #400 revealed an admission date of 6/1/18 with diagnoses of post-traumatic stress disorder, schizoaffective disorder, bipolar, and dementia. Functional capacity screen dated 6/1/18 indicated resident was independent with dressing, transferring, mobility and eating; required supervision with bathing and toileting; was unable to perform management of medications and treatments; and experienced impaired decision making. Wellness notes contained documentation by licensed nurse C as follows: 6/1/18 at 5:00 p.m. admission note of resident awake and alert to person, place, and situation/time. Ambulates with a steady gait. History and physical reviewed. Medications	S5251		

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S5251	Continued From page 30	S5251		

reviewed/reconciled. Assessments completed.

Next entry dated 7/1/18 of no new behaviors noted. Does spend time in room and chooses not to socialize. No change in medications.

The resident's record lacked documentation to indicate reason resident required hospitalization for behavior management or documentation that resident was admitted to a behavioral health unit. The record lacked an order from the resident's medical care provider to transfer resident to the behavioral health unit.

During an interview at 1:22 p.m. on 7/19/18, operator B stated resident was admitted to behavioral health unit on 7/11/18 due to secluding self in room and refusing care. Operator B stated someone from the behavioral health unit came to assess resident and wanted resident admitted for medication adjustment.

At 11:48 a.m. on 7/23/18, licensed nurse C stated he/she called the contact person at the behavioral health unit due to resident isolating self and not adjusting to the facility. Licensed nurse C stated he/she would walk into resident's room and resident "would look at me like (resident) was going to kill me." Surveyor informed licensed nurse C that the record lacked documentation of need to be admitted to behavioral health unit and the date of admission. Licensed nurse C stated he/she had an order dated 7/9/18 for transfer from the facility and admission to the behavioral health unit.

Operator B failed to ensure resident #400's record contained documentation of all incidents, symptoms, and other indications of illness including the date, the time of occurrence, the

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S5251	Continued From page 31 action taken, and the results of the action.	S5251		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1)(3) The facility reported a census of 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on record review and interview for 2 of 5 employee files reviewed, operator B failed to	S5258		

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S5258	Continued From page 32 ensure the file of licensed nurse C contained documentation of licensure as a registered nurse in Kansas and the file of certified staff F contained documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home. Findings included: - Review of personnel files at 11:06 a.m. on 7/23/18 with operator B revealed the file of licensed nurse C hired 1/9/18 lacked documentation obtained prior to or on employment date that the employee was currently licensed as a nurse in the state of Kansas. The file of certified staff F with employment date of 1/12/18 contained documentation dated 1/18/18 from the Kansas nurse aide registry that the employee was certified as a medication aide. At 11:09 a.m. on 7/23/18, operator B stated he/she was unable to access the Kansas nurse aide registry on or before 1/12/18 and (certified staff F began working in the facility on 1/12/18. At 11:18 a.m., operator B stated he/she checked the Kansas board of nursing website to confirm the nurse was licensed but did not print the document to place in the employee's file. Operator B failed to ensure the file of licensed nurse C contained documentation of licensure as a registered nurse in Kansas and the file of certified staff F contained documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home.	S5258		

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S5316	Continued From page 33	S5316		
S5316 SS=E	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i)(1)(A)(B) The facility reported a census of 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on record review and interview for 1 (#100) of 3 residents sampled, and 1 closed record reviewed	S5316		

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S5316	Continued From page 34 (#600), licensed nurse C failed to ensure the destruction of discontinued controlled medications by 2 licensed nurses or a licensed nurse and a licensed pharmacist. Findings included: - Record review for resident #100 revealed an admission date of 5/4/18 with diagnosis of Alzheimer's dementia. Functional capacity screen dated 5/4/18 indicated resident was unable to perform management of medications. Negotiated service agreement and health care service plan dated 5/4/18 documented certified medication aides administered medication to the resident with licensed nurse C supervising this service. Record contained documentation signed by licensed nurse C and certified staff G wasted 0.9 milliliter of Ativan (a controlled antianxiety medication) 1 milligram per 0.1 milliliter, - Record review for discharged resident #600 revealed an admission date of 4/23/18 with diagnoses of schizophrenia, anxiety, and diabetes mellitus type 2. The record lacked a functional capacity screen. The negotiated service agreement/health care service plan documented medication administration by certified staff. Record contained documentation signed by licensed nurse C and certified staff H on 6/24/18 of the destruction of the following controlled medications: Lorazepam (controlled antianxiety medication) 0.5 milligram (mg) 30 tablets. Lorazepam 0.5 mg 5 tablets.	S5316		

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S5316	Continued From page 35 Lorazepam 0.5 mg 16 tablets. Lorazepam 0.5 mg 21 tablets. Clonazepam (controlled antianxiety medication) 0.5 mg 1 tablet. Clonazepam 0.5 mg 3 tablets. During an interview at 10:21 a.m. on 7/23/18, certified staff D stated (licensed nurse C) and a medication aide usually destroyed controlled medications. At 11:28 a.m. on 7/23/18, when asked about destruction of controlled medications that have been discontinued or expired, licensed nurse C stated he/she and a medication aide crushed the medications, placed the medications in coffee grounds and placed in trash. Licensed nurse C stated he/she and medication aide documented the number of medications destroyed. At this time, operator B provided the facility's policy for medication disposal that recorded discontinued or outdated controlled substances shall be destroyed by the registered nurse in the presence of a licensed pharmacist and recorded in the resident's record. Licensed nurse C failed to ensure the destruction of discontinued controlled medications by 2 licensed nurses or a licensed nurse and a licensed pharmacist.	S5316		
S5335 SS=D	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 36 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 5 residents. The sample included 3 residents, 1 focus review resident, and review of 2 closed records. Based on record review, observation, and interview for 1 (#100) of 3 residents sampled, operator B failed to ensure cleaning supplies were not accessible to the cognitively impaired resident. Findings included: - Record review for resident #100 revealed an admission date of 5/4/18 with diagnosis of Alzheimer's disease. Functional capacity screen dated 5/4/18 indicated resident was independent with ambulation; required supervision with toileting; experienced impaired short-term memory, long-term memory, memory recall, and decision making; exhibited wandering behavior. Negotiated service agreement dated 5/4/18 documented resident required "Constant monitoring, always picking up items and moving stuff." During time in the facility on 7/19/18, surveyor	S5335		

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S5335	Continued From page 37 observed resident wandering in facility. At 3:34 p.m. on 7/19/18, surveyor observed resident's room with an attached bathroom. The vanity cabinet, accessible to resident, below the bathroom sink contained a partial bottle of Lysol spray disinfectant, a full bottle of Clorox toilet bowl cleaner, an open box of baking soda, denture cleaning tablets, and an unlabeled plastic specimen cup with pink liquid. Surveyor observed a 3/4 full 24-ounce bottle of Mr. Clean multi-purpose cleaner in a drawer in the vanity cabinet. At 3:38 p.m. on 7/19/18 surveyor asked operator B to come to resident's bathroom and observe these items. Certified staff E also present and stated the resident's family brought the cleaning items and placed them in the resident's bathroom. Operator B removed the items from the resident's bathroom and locked the cleaning supplies with facility cleaning supplies. Operator B failed to ensure cleaning supplies were not accessible to cognitively impaired resident #100.	S5335		
S5345 SS=F	28-39-437 Building Exterior (d) General building exterior. (1) Each exterior pathway or access to the facility's common use areas and entrance or exit ways shall meet the following requirements: (A) Be made of hard, smooth material; (B) be barrier free; and	S5345		

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S5345	Continued From page 38 (C) be maintained in good repair. (2) Outdoor recreation areas shall be provided and available to residents. (3) The exterior of the building and the grounds shall be maintained in good repair and in a clean, safe, and orderly manner. (4) Each facility house address number shall be posted on the exterior of the facility using at least three-inch-high numbers. Address numbers shall be posted on any mailbox located away from the facility. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(d)(1)(B) The facility reported a census of 5 residents. The sample included 3 residents, 2 focus review residents, and review of 2 closed records. Based on observation and interview for the safety of all residents, operator B failed to ensure a fire exit was barrier free. Findings included: - At 11:18 a.m. on 7/19/18, surveyor observed operator B go to the front door of the facility and unlock a dead bolt lock with a key and then turn the door knob to open the front door. Operator B stated and confirmed the front door could not be opened by turning the door knob without using a key to unlock the deadbolt lock. Review of the resident roster revealed each of the 5 residents experienced impaired cognition. Record reviews and observations on 7/19/18 revealed the following:	S5345		

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S5345	Continued From page 39 Resident # 100 with diagnosis of Alzheimer's disease wandered about without assistance and required frequent redirection. Resident #200 with diagnosis of chronic obstructive pulmonary disease remained in bed on 7/19/18. Functional capacity screen dated 6/13/18 indicated resident was unable to mobilize self and required a wheelchair for mobility. Certified staff D stated resident was blind. Resident #300 with diagnosis of bipolar disorder. Surveyor observed resident mobilize self in wheelchair throughout facility. Non-sampled resident #450 was dependent on certified staff to transfer and propel wheelchair. Resident #400 was not in the facility on 7/19/18 but did return 7/24/18. Resident's functional capacity screen dated 6/1/18 indicated resident was independent with ambulation. For all residents, operator B failed to ensure a fire exit was barrier free.	S5345		