STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	R 07/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER ROAD WICHITA, KS 67212

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{S 000}	INITIAL COMMENTS The following citations represent the findings of the second non-compliance revisit for the above named facility conducted on 7/3/18 and 7/5/18. Revised 2567 and 2567B sent to facility 7/10/2018	{S 000}		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (a) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure staff provided the mechanically altered diet as ordered by a physician and per the negotiated service agreement for 1 of 3 sampled residents (#2102). Findings included:	S5185		

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

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S5185	Continued From page 1 - Record review revealed an admission dated of 4/8/17 with diagnoses of dementia, chronic heart failure, chronic kidney disease, hypertension and chronic obstructive pulmonary disease. The annual functional capacity screen dated 4/20/18 indicated the resident needed physical assistance with eating. The negotiated service agreement dated 4/20/18 included a mechanical soft diet with thin liquids, staff to fed the resident when needed, follow instructions on diet preparation and will ensure resident is brought to all meals. The health service plan dated 4/20/18 included mechanical soft diet with thin liquids, any change in diet must be evaluated by a dietician/speech therapist/or doctor. Staff will follow all instructions for diet - see physician orders in kitchen. Review of a notice posted in the kitchen area titled "Attention Dietary" and signed by the physician on 3/28/18 revealed the following mechanical diet ordered for the resident due to swallowing issues. Therefore, the food he/she eats must be soft and easy to chew and swallow. Softness of the food depends on: the food itself, how the food is cooked and how long the food is cooked. The resident's meals will be served in the following way: meat will be cut into pieces no bigger than 1/4 inch, vegetables will be well cooked and large vegetables will be cut into pieces no bigger than 1/4 inch, whole raw apples will not be served. Soups all types with soft ingredients as tolerated. Breads and cereals include all types without hard-to-chew ingredients or crust and noodles as tolerated."	S5185		

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S5185	Continued From page 2	S5185		

Review of a generalized mechanical soft diet also posted in the kitchen identified fruits should be applesauce, drained canned fruits, soft fresh fruits such as peaches, nectarine without skin, melon, berries and bananas.

Review of the physician's orders revealed an order dated 3/15/18 for a swallow study. Review of the record revealed no results of the swallow study.

Review of the resident progress notes between 5/17/18 and 7/3/18 revealed an entry dated 6/10/18 and marked as a late entry for 6/3/18 at approximately 12:30 PM resident choked on chicken strip while eating lunch meal during "cook out". Appeared to get all the chicken coughed out. On 6/4/18 licensed nurse F notified the nurse practitioner at 2:10 PM about the incident and asked for a chest X-ray due to increased congestion. Licensed nurse F recorded "staff educated again regarding mechanical soft diet and where instructions were located". At 4:07 PM results of X-ray were no sign of aspiration.

Review of the chest X-ray results dated 6/4/18 revealed no focal pneumonia or evidence for aspiration.

Observation on 7/3/18 at 11:29 AM certified medication aide (CMA) A placed a bowl of canned sliced peaches in front of the resident with some of the slices cut in half (approximate size of peach chunks was 1/2 inch or greater). CMA A walked away back towards the kitchen and the resident was in the front dining room and not in view. The resident picked up the spoon and put 2 pieces of the peaches into his/her mouth at one time. The resident appeared to have no visible teeth. He/she almost continuously made

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S5185	Continued From page 3 involuntary grunts, noises and gurgling sounds during the eating of the peaches. At 11:57 AM CMA A placed a bowl of soup with potatoes, carrots and meat in small pieces. CMA A gave the resident a spoonful of soup which the resident immediately spit out and said "too hot" and CMA A set it aside to cool. Observation revealed steam coming off the soup. Interview on 7/3/18 at 12:09 PM with CMA A and licensed nurse D revealed staff should have cut the peaches into 1/4 inch pieces. Interview on 7/3/18 at 1:45 PM with CMA A revealed he/she knew to cut up the meat and vegetables but did not know about the fruit until today after lunch. The operator failed to ensure staff provided the mechanically altered diet as ordered by a physician and per the negotiated service agreement for this resident.	S5185		
{S5240} SS=E	26-42-105 (a) Resident Records (a) The administrator or operator of each home plus shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer.	{S5240}		

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{S5240}	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (a) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to maintain the medical record for 2 of 3 sampled residents (#2101 and #2103) in accordance with accepted professional standards and practices. Findings included: - On 7/3/18 at 8:45 AM observation revealed resident #2101 sat in a wheelchair at the dining room table finishing breakfast. At 9:05 AM observation of the rack with the resident's medical charts revealed no chart for resident #2101. On 7/3/18 at 9:10 AM certified medication aide (CMA) A did not know where the resident's chart/medical record information was located. Interview on 7/3/18 at 10:06 AM with CMA C said there was no formal chart put together yet for the resident and he/she did not know where the medical information for the resident was located. He/she looked in the medication room where all the other residents' charts were located. He/she looked at the nursing desk area and then he/she contacted the operator by phone to determine the location of the medical information for the resident. Review of the records contained within a large envelope provided by CMA C revealed an admission date for resident #2101 of 6/12/18.	{S5240}		

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{S5240}	Continued From page 5 The operator failed to maintain the medical record for this resident in accordance with accepted professional standards and practices. - On 7/3/18 at 9:05 AM observation revealed a medical chart in the rack for resident medical charts which was labeled with resident #2104's name. Interview with CMA A on 7/3/18 at 9:10 AM revealed resident #2104 no longer resided at the facility. He/she did not know the disposition of the resident or when the resident left the facility. Interview on 7/3/18 at 10:05 AM with CMA C revealed the resident had passed away sometime in April of 2018. He/she did not know why the chart was still in the rack of charts. Review of the care notes revealed the start of an entry recorded as a late entry (LE) in April of 2018 with no further documentation to indicate the disposition of the resident. The operator failed to maintain the medical record for this resident in accordance with accepted professional standards and practices. - Record review for resident #2103 revealed an admission date of 7/1/11 with diagnoses of hypertension, gout, fluid retention, dizziness and depression. Review of the care notes revealed an entry dated 6/8/18 with no time - notified physician that blood was coming out of the resident's urethra. The physician ordered a urinalysis (UA) by straight catheter and culture and sensitivity. Licensed nurse (no name specified and enter not signed)	{S5240}		

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{S5240}	Continued From page 6 with CMA E straight catheterized the resident. Resident was in pain when the catheter went in even with use of Lidocaine and UA sent to laboratory (lab). An entry dated 6/10/18 at 2:13 PM included no growth on culture at this time. continued to state "partial preliminary" which was faxed to the physician on 8/10/18 at 6:06 AM - continue to wait for final (signed by licensed nurse F). Record review on 7/3/18 revealed no written physician order in the chart for obtaining a urine specimen by straight catherization and the last physician order in the chart was dated 5/14/18. The physician orders included an order on 1/28/16 Lidocaine gel for pain on wound of gender part (urethra). The record lacked any orders to use Lidocaine with catheter insertion. Review of the lab section revealed the last lab results on the chart were dated 8/28/17. Request for any additional unfiled records resulted in lab results for 6/28/18 but none for the UA on 6/8/18. Licensed nurse D called the laboratory and obtained a copy of the 6/8/18 UA. Interview on 7/3/18 at 11:25 AM with licensed nurse D confirmed the record lacked a written physician order for the straight catherization, urinalysis, use of Lidocaine and the lab results of the UA done on 6/8/18. The operator failed to maintain the medical record for this resident in accordance with accepted professional standards and practices.	{S5240}		
{S5251} SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents	{S5251}		

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{S5251}	Continued From page 7 (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) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, interview and record review for 1 of 3 sampled residents (#2103), the operator failed to ensure the 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. Findings included: - Record review for resident #2103 revealed an admission date of 7/1/11 with diagnoses of hypertension, gout, fluid retention, dizziness and depression. The annual functional capacity screen dated 8/5/17 indicated the resident required physical assistance with bathing, dressing, toileting, transfers and walking/mobility. The negotiated service agreement dated 8/5/17 directed staff to provide the resident assistance with bathing, dressing, toileting and 2 staff for transfers. The resident required 1 staff to move about in a wheelchair. The licensed nurse will educate certified staff on proper transfer technique to avoid skin tears and other injuries when transferring resident. A licensed nurse will	{S5251}		

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{S5251}	Continued From page 8 assess, treat, and manage pressure wound and skin tears per physician orders and standard care of nursing; delegating duties to educate certified staff as appropriate. Review of the care notes between 5/17/18 and 7/3/18 revealed 6 entries about a stage 2 wound without a specified location but indicated an intervention of sitting on an air cushion while in the wheelchair and turning side to side. The record lacked any information about any other skin conditions. Review of skin monitoring bath sheets provided by certified medication aide (CMA) A revealed the following: On 6/22/18 staff marked bruising, skin tears and lesions were present without locations. On the body image staff marked the right lateral leg above the knee, below the knee and to the outer foot. The nurse section was blank. On 6/26/18 staff marked item #1 bruising on the body image of both hands and both lateral knees and skin tears on the left shoulder and right toes. The nurse section was blank. On 6/29/18 staff marked bruising, abnormal color and abnormal skin without any locations or marks on the body image. The nurse section was blank. Observation on 7/3/18 at 11:34 AM revealed CMA A and certified nurse aide (CNA) B transferred the resident to the toilet. The resident's left knee had an open area on his/her left outer knee approximate size of nickel. The wound appeared as a shallow crater with dried wound edges, slight amount of yellow slough in one part of the wound bed and no surrounding redness. On the lateral	{S5251}		

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{S5251}	Continued From page 9 side of the left knee was a large discolored/bruised area about the size of a half dollar. The right lateral knee also had a quarter sized discolored/bruised area. Interview on 7/3/18 at 11:34 AM with CNA B revealed he/she lacked awareness of the resident's open area and bruising on his/her knees. Interview on 7/3/18 at 11:34 AM CMA A reported noticing the bruising during the resident's shower this morning but did not notice the open wound. He/she reported staff should complete the skin sheet with the showers and tell the nurse of any areas found. Interview on 7/3/18 at 11:45 AM with CMA C revealed when he/she last saw the resident's left knee there was a scab on it. He/she did not know how long the resident had the open area and bruising. He/she reviewed the record and confirmed the record lacked any documentation about the skin conditions, cause of the condition, actions taken or results of actions taken. Licensed nurse D did not know about the resident's skin condition. He/she also reviewed the record and confirmed the record lacked any information about the resident's skin conditions on his/her knees. The operator failed to ensure the 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 for this resident with an open wound and bruising on bilateral knees.	{S5251}		

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{S5258}	Continued From page 10	{S5258}		
{S5258} SS=D	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) The facility reported a census of 7 residents. Based on interview and record review the operator failed to have evidence of licensure verification for 1 of 1 licensed nurse hired since last survey (licensed nurse A). Findings included:	{S5258}		

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{S5258}	Continued From page 11 - The facility provided a list of 1 staff member hired since the last survey on 5/17/18. Review of the personell file for licensed nurse A revealed a hire date of 6/26/18 with no evidence of licensure verification. On 7/3/18 at 10:50 AM certified medication aide (CMA) B (in charge during operator abscence) confirmed the personell file lacked evidence of licensure verification for licensed nurse A prior to starting employment. On 7/3/18 at 2:00 PM licensed nurse A also confirmed the file lacked verficiation of his/her license and reported checking it 7/3/18 and placing a copy in the file. The operator failed to have evidence of licensure verification for 1 of 1 licensed nurse hired since last survey (licensed nurse A).	{S5258}		