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	B087167	A. BUILDING: _____ B. WING _____	R 05/17/2018

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 non-compliance revisit of the above named facility conducted on 5/14/18, 5/15/18, 5/16/18 and 5/17/18.	{S 000}		
{S5155} SS=G	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26- 42-204(a) The facility reported a census of 6 residents. The sampled included 3 residents and 1 focused sample for bed rail use. Based on observation, interview and record review Licensed nurse/operator E failed to provide or coordinate 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 for 1 of 3 sampled residents (#1203). Resident #1203 had a history of a pressure ulcer on the right buttock, had redness and breakdown which resolved and reappeared. The Negotiated Service Agreement (NSA) and Health Service Plan (HSP) lacked interventions for prevention of pressure ulcer development or to promote healing of existing	{S5155}		

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

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wounds. The pressure area on the right buttock went from redness only to a stage 2 (partial thickness open area) pressure ulcer between (5/11/18 and 5/14/18).

Findings included:

- Record review revealed resident #1203 admitted to the facility on 7/1/11. His/her diagnoses included: abdominal mass, splenomegaly, hypertension, fluid retention and incontinent episodes.

The annual Functional Capacity Screen dated 8/5/17 indicated the resident needed physical assistance with toileting, transfers, dressing and mobility. He/she experienced total urinary incontinence and was cognitively impaired with impaired decision making.

The Negotiated Service Agreement (NSA) dated 8/5/17 listed risk factors for pressure wounds "immobility, altered mental status, dry skin, previous pressure wounds, edema, incontinence, malnutrition, dehydration, resident not being turned, age 70 or older and multiple other factors. The registered nurse (RN) will educate certified staff on preventative measures to avoid pressure wounds by following the facility policies and procedures (updated 7/2015)". The portion for assessing, treating and managing pressure wounds included "RN will assess, treat and manage pressure wounds per physician orders and standard care of nursing; delegating duties to educated certified staff as appropriate". The NSA lacked any individualized interventions for this resident's risk factors and needs. The NSA lacked an update after the development of the area to promote healing, prevent worsening or development of additional areas.

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{S5155}	Continued From page 2 The NSA indicated the resident was unable to dress/undress him/herself, unable to toilet self and required 2 staff to transfer him/her on and off the toilet and required staff assist with personal hygiene needs and managing incontinence. The resident used a wheelchair for mobility and required 1 staff to move the wheelchair. The Health Service Plan (HSP)/care plan dated 8/5/17 directed staff to provide 1 staff assist for the resident with mobility and use of wheelchair, he/she was unable to self-transfer and required assistance of 2 staff. The resident was unable to feed him/herself and required staff to feed him/her. Staff needed to dress/undress the resident and to assist with all hygiene and grooming needs for the resident. The resident required the assistance of 2 staff to transfer from the wheelchair to the toilet and back to the wheelchair. During the hours of sleep (HS) staff will check and change the resident's incontinence as needed. The RN will assess resident and report any changes in resident's health status and notify physician and power of attorney. The HSP/care plan lacked any information related to pressure ulcer risk, skin breakdown or actual pressure ulcers with no interventions for prevention or promote healing. Record review revealed a physician communication signed 3/28/16 which indicated the resident had a history of a stage 2 pressure ulcer to the right buttock which was related to the resident sleeping in the recliner. The wound improved with relived pressure of sleeping in bed rather than the recliner. The note indicated staff were advised to reposition the resident every 1 hour when in the chair and every 2 hours when in	{S5155}		

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the bed. This intervention was not reflected in the NSA or the HSP/care plan.

License nurse/operator E identified the resident with a skin condition on the resident roster completed at entrance meeting on 5/14/18. He/she reported on 5/14/18 at 12:30 PM the resident had developed a stage 2 pressure ulcer (partial thickness skin loss related to prolonged pressure) from staff bringing him/her back out to the recliner to soon and let him/her sit too long. He/she did not know a specific date when the area started and said it comes and goes.

Review of the physician orders revealed no orders regarding treatment of a pressure ulcer. The orders included "Boudreauxs butt paste" apply as needed (PRN) since 1/29/16, Risamine ointment apply thin layer on affected layer 2-4 times daily or after each incontinent episode PRN until healed since 1/10/18.

Review of the April 2018 medication/treatment administration record (MAR/TAR) revealed no documented applications of the Boudreauxs butt paste or Risamine ointment. The MAR/TAR included a hand-written direction of dressing changes on bottom every 3 days or PRN (foam) with no date of starting but initialed by staff on 4/2, 3, 5, 7, 9, 10, 13, 14, 15, 18, 21, 23, 26 and 4/29/18.

Review of the May 2018 MAR/TAR revealed no documented applications of the Boudreauxs butt paste or Risamine ointment. The MAR included a hand-written direction for dressing changes on bottom every 2 days without a date and initialed by staff on 5/5/18, 5/8/18, 5/11/18 and 5/13/18.

Review of the resident progress notes revealed

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the last entry dated 1/11/18 by the resident's physician which did not included any information about assessment or treatment of the resident's buttocks. The notes prior to that note were dated 3/9/17 through 9/27/17. The record lacked any evidence of a nurse assessment regarding the resident's change in health status or notification of the physician regarding the skin condition.

Observation on 5/14/18 at 11:50 AM the resident sat in a wheelchair at the dining room table. At 12:38 PM the resident now rested in a reclined position of a recliner in the living room. He/she had a slight lean to the left but the lower back, sacral and coccyx area remained in contact with the back of the recliner. Interview at 12:38 PM with certified medication aide (CMA) B revealed he/she had just transferred the resident from the wheelchair to the recliner. Observation at 12:50 PM, 1:12 PM, 1:35 PM, 1:50 PM, 2:10 PM, 2:25 PM and 2:40 PM revealed the resident remained in the same position in the recliner with his/her eyes closed. Interview at 2:40 PM with CMA A revealed staff asked the resident if he/she needed to use the restroom at around 2:30 PM. When asked if the resident was provided a position change he/she said no, but we could go ahead and do that, it is right at 2 hours. When asked how often did the resident need to be repositioned he/she said every resident was repositioned every 2 hours.

Observation on 5/14/18 at 2:45 PM revealed CMA A and CMA B transferred the resident from the wheelchair to the toilet. The resident had been incontinent of urine. The resident had a foam type dressing in place at the upper edge of the gluteal crease and down towards the distal aspect of the gluteal crease. The edges of the dressing were peeling away from the resident's skin. The

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dressing was dated 5/13/18. After the toileting the resident was transferred back to the wheelchair and returned to the living room.

Observation on 5/14/18 at 3:39 PM CMA A and CMA C transferred the resident from the wheelchair to the bed and positioned the resident on his/her right side to allow licensed nurse/operator E to assess and perform the dressing change. Licensed nurse/operator E reported the wound was much worse than it was on Friday 5/11/18 when he/she last looked at it. He/she measured an overall area of non-blanchable redness with skin peeling as 5.4 centimeters (cm) in length and 2.7 cm wide. The open area which presented as a small crater with yellow slough in the wound bed measured 1.2 cm long by 1.3 cm wide. Interview with licensed nurse/operator E at that time revealed this was the worst he/she had even seen the resident's area. He/she said the resident spends time in the recliner or wheelchair. He/she planned to clean the area with a normal saline spray, apply diaper rash ointment with zinc oxide to the entire area and cover the opening with a Mepilex 3 by 3-inch foam type dressing. He/she said the staff were supposed to be lifting the resident every hour when in the recliner and repositioning every 2 hours when in bed.

Interview on 5/14/18 at 2:40 PM with CMA A revealed he/she was a new employee in past month and he/she was not aware the resident had a pressure ulcer. He/she did not know of any pressure ulcer prevention interventions other than repositioning each resident every 2 hours.

Interview on 5/14/18 at 2:41 PM with CMA B revealed he/she was a new employee in past month and he/she knew the resident had a skin

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condition which he/she put the diaper rash cream on when incontinent. He/she did not know anything about the wound dressing which was in place and reported the nurse does the dressing change. He/she reported the resident was repositioned every 2 hours.

Interview on 5/15/18 at 10:15 AM with CMA D revealed he/she was a new employee in past month. He/she indicated being trained by a peer and being told what the resident care needs were. He/she was not told about the resident's pressure ulcer risks. He/she said the resident was a 2 person assist to transfers and was up in the wheelchair for meals only. The resident usually sat in the recliner after meals. He/she reported the wound was present when he/she began working at the facility and staff were putting a honey ointment on it not the diaper rash cream but he/she could not remember the name of it. The wound was covered by a bandage. The staff usually laid the resident in the bed after lunch. He/she could not remember about a cushion being in the wheelchair before today. He/she would put pillows at the resident's side to tip his/her hips when in bed. He/she said the resident was repositioned every 2 hours.

Interview with licensed nurse/operator E on 5/15/18 at 10:48 AM confirmed the NSA and HSP lacked interventions for prevention of pressure ulcers, the actual development of a pressure ulcer and interventions to promote healing. He/she said staff were to turn and reposition the resident every hour when in the chair but the area did not get better. He/she reported obtaining a "special air cushion" on the evening of 5/11/18 for the resident to use when in the wheelchair. He/she confirmed the recliner had no pressure relieving cushion in place when the resident was

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{S5155}	Continued From page 7 in the recliner. On 5/14/18 at 5:00 PM nurse practitioner F assessed the resident's wound as a stage 2 (partial thickness) pressure ulcer which sits at the inferior aspect of the gluteal cleft. The wound was bright pink with central area of skin avulsion (skin is lost or too damaged to be repaired and cannot be stitch closed due to missing tissue). The wound area did blanch and was approximately 5 cm in length (at longest part) and 3 cm in width (at widest part). Plan to order Home Health to evaluate and treat wound. In meantime staff will keep the area clean and dry with a dressing over the wound until further recommendation by Home Health, continue routine offloading (repositioning) of wound per facility protocols. Review of the facility's undated Pressure Wound Prevention and Management policy revealed the policy/procedure was to ensure the facility meets the best practice standards for prevention and management of pressure wounds according to national, regional and state guidelines. All staff will act in accordance with this policy to prevent the development of pressure wounds or to prevent deterioration of existing wounds. The policy listed risk factors of: immobility, friction and shear, moisture, incontinence, poor nutrition, perfusion, age, skin condition and decreased level of cognition. The RN will assess upon admission and give nursing orders for wound preventions when necessary. All resident who were bedfast and/or chair fast are at risk of developing pressure wound. Chair bound resident have almost 50% of their weight on only 8% of their body. Therefore, the sacrum and buttocks are at increased risk. Review of the facility's undated How to Care for	{S5155}		

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{S5155}	Continued From page 8 Pressure Sores policy revealed pressure sores or bed sores are painful skin ulcers that form when constant pressure on a part of the body shuts down the blood vessel feeding that area of skin. The resulting damage first appears on the skin surface as a red or dark patch. As the pressure sore progresses, the skin will break down to form blisters, dead skin and ultimately infect underlying tissues, bones and joints. As little as 2 hours of sustained pressure will trigger skin damage. Skin damage can also be exacerbated by friction and moisture. In the early stages, pressure sores can be treated by relieving the pressure, cleaning the sores and applying the appropriate dressing. In later stages of severity, professional medical treatment or possibly surgery will be necessary. Pressure sores are especially prevalent on the lower back and buttock and any bony protruding areas. People who are bed-bound or in wheelchairs are particularly susceptible to pressure sores. Licensed nurse/operator E failed to provide or coordinate the provision of necessary health care services for this resident to ensure the resident's needs are met in accordance with the functional capacity screening and the negotiated service agreement. Resident #1203 had a history of a pressure ulcer on the right buttock, had redness and breakdown which resolved and reappeared. The Negotiated Service Agreement (NSA) and Health Service Plan (HSP) lacked interventions for prevention of pressure ulcer development or to promote healing of existing wounds. This area went from redness to a stage 2 pressure ulcer between (5/11/18 and 5/14/18).	{S5155}		
S5240 SS=E	26-42-105 (a) Resident Records	S5240		

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S5240	Continued From page 9 (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. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(a) The facility reported a census of 6 residents with 3 sampled and 1 for focus sample related to safety. Based on observation, interview and record review licensed nurse/operator E failed to ensure the resident records for 2 of 4 residents sampled was maintained in accordance with accepted professional standards of practices (#1201 and #1204). Findings included: - Record review for resident #1201 revealed an admission date of 6/20/17. He/she had diagnoses of stage 4 prostate cancer with metastasis to bone and gastric bleed. The significant change Functional Capacity Screen (FCS) dated 5/8/18 identified the resident needed physical assistance with bathing, dressing, transfers, walking and mobility.	S5240		

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S5240	Continued From page 10 The Negotiated Service Agreement (NSA) dated 5/8/18 included staff needed to provide 1-2 person assist with showering, dressing/undressing, transfer to toilet and mobility per wheelchair. He/she had a urinary catheter which staff emptied and provide catheter care. He/she had memory recall deficit and impaired decision making. The Health Service Plan (HSP) dated 5/8/18 directed staff to provide 1 staff assistance with mobility and use of a wheelchair. The HSP included staff names who can transfer the resident with 1 staff member otherwise the resident needed 2 staff to transfer. Staff should assist with dressing/undressing and personal hygiene/grooming. He/she had a urinary catheter and required 2 staff assistances with toileting needs. Registered nurse (RN) will assess resident and report any change in resident's health status and notify physician and power of attorney. Review of the resident progress notes dated 5/2/18 at 7:10 PM and not identified as a late entry indicated on 5/1/18 at 7:50 PM licensed nurse/operator E notified the resident's physician of the resident wheezing on expiration had a temperature of 99.4 degrees Fahrenheit and had shortness of air stating he/she did not feel well. The physician ordered portal chest X-ray (PCXR), complete blood cell count (CBC) and comprehensive metabolic panel (CMP). Review of the physician's orders revealed a telephone order written for the PCXR but not for the CBC or CMP. Interview on 5/15/18 at 10:30 AM with licensed	S5240		

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S5240	Continued From page 11	S5240		

nurse/operator E revealed he/she had a communication via cell phone text messaging with the physician that included orders for the PCXR, CBC and CMP. The licensed nurse/operator E confirmed the record lacked written orders for the CBC and CMP.

Review of the resident progress notes revealed the last entry in the record was dated 5/8/18 at 11:50 AM. When asked if licensed nurse/operator had made any other entries since 5/8/18 about the resident's condition he/she said, "I think I was writing that today when surveyors arrived". He/she then provided the note which was dated 5/14/18 at 9:20 AM and not identified as a late entry. He/she indicated it was the information about the resident's readmission.

The American Nurses Association 2010 advised clear, accurate, and accessible documentation is an essential element of safe, quality and evidence-based nursing practice.

The AHC media publishing (a standard in medical publications) recommend when an entry into the medical record cannot be made timely due to emergency situation the record should reflect the current date and time; a reference to the entry as a "late entry" or "addendum" to the prior record.

Licensed nurse/operator E failed to ensure resident #1201's legal medical record was maintained in accordance with accepted professional standards of practices.

- Record review for resident #1204 revealed an admission date of 2/11/11 with diagnoses of chronic obstructive pulmonary disease (COPD), urinary tract infection (UTI), anxiety and pain.

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S5240	Continued From page 12 The annual Functional Capacity Screen (FCS) dated 3/5/18 indicated the resident needed physical assist with activities of daily living (ADLs) such as bathing, dressing/undressing, toileting, transfers, walking/mobility and eating. He/she had short and long-term memory deficit, memory recall deficit and impaired decision making. The Negotiated Service Agreement (NSA) dated 3/5/18 included for staff to provide physical assistance of 1 staff for ADLs as listed in FCS. The NSA indicated licensed nurse/operator E would be responsible for supervised nursing services. The NSA listed risk factors for pressure wound which included: immobility, altered mental status, dry skin, previous pressure wounds, edema, incontinence, malnutrition, dehydration, significant weight loss, resident not being turned, age 70 and older and multiple other factors. Under Assessing, treating and managing pressure wounds - Registered nurse (RN) will assess, treat and manage pressure wounds per physician orders and standard care of nursing; delegating duties to educated certified staff per regulations, ensuring education requirement have been met. Certified medication aides (CMAs) and/or RN will administer all physician ordered medications and treatments. The Health Service Plan (HSP)/care plan dated 3/5/18 directed staff to provide physical assistance with ADLs as listed in FCS. The resident will receive medical treatment at the facility from medical director. RN is responsible for obtaining physician orders and sending new orders to the pharmacy. RN will assess resident and report any change in resident's health status, notify physician and power of attorney. On 5/14/18 at approximately 1:30 PM licensed	S5240		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5240	Continued From page 13 nurse/operator E reported he/she needed to give the resident a Rocephin intramuscularly (IM) injection. Review of the physician orders on 5/14/18 at 2:30 PM revealed a telephone order dated 5/12/18 for Rocephin 1-gram IM daily for 7 days to treat UTI. Review of the MAY 2018 medication administration record (MAR) revealed no order written on the MAR. The licensed nurse/operator E confirmed the MAR lacked the physician order for Rocephin. Review of the resident progress notes revealed a full page of documentation ranging from 3/14/17 at 6:15 PM to 3/23 (no year) and no time. The next page had an entry dated 5/1/17 at 3:50 AM which took 5 lines of the page leaving 20 lines blank. Observation on 5/14/18 at 2:00 PM revealed 5 vials of Rocephin filled on 5/14/18 were in the medication room. Observation on 5/14/18 at approximately 3:00 PM revealed licensed nurse/operator E wrote the order on the May 2018 MAR and prepared to administer the medication. On 5/15/18 at 1:35 PM licensed nurse/operator E provided documentation which he/she added to the resident's record. The resident progress note began (4/27/18) and under that was 5/15/18 8:30 AM. The note reflected the resident's change in condition on 4/29/18 with subsequent lab work on 5/9/18, results on 5/12/18 and orders for an antibiotic and subsequent phone call with pharmacy on 5/14/18. The American Nurses Association 2010 advised	S5240		

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S5240	Continued From page 14 clear, accurate, and accessible documentation is an essential element of safe, quality and evidence-based nursing practice. The AHC media publishing (a standard in medical publications) recommend when an entry into the medical record cannot be made timely due to emergency situation the record should reflect the current date and time; a reference to the entry as a "late entry" or "addendum" to the prior record. Licensed nurse/operator E failed to ensure resident #1204's legal medical record was maintained in accordance with accepted professional standards of practices.	S5240		
{S5251} SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 6 residents. The sampled included 3 residents and 1 focused review for safety concerns. Based on record review and interview licensed nurse/operator E failed to ensure 4 of 4 sampled resident records included 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 (#1201, #1202,	{S5251}		

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{S5251}	Continued From page 15 #1203 and #1204). Findings included: - Record review for resident #1201 revealed an admission date of 6/20/17. He/she had diagnoses of stage 4 prostrate cancer with metastasis to bone and gastric bleed. The significant change Functional Capacity Screen (FCS) dated 5/8/18 identified the resident needed physical assistance with bathing, dressing, transfers, walking and mobility. The Negotiated Service Agreement (NSA) dated 5/8/18 included staff needed to provide 1-2 person assist with showering, dressing/undressing, transfer to toilet and mobility per wheelchair. He/she had a urinary catheter which staff emptied and provided catheter care. He/she had memory recall deficit and impaired decision making. The Health Service Plan (HSP) dated 5/8/18 directed staff to provide assistance of 1 staff with mobility and use of a wheelchair. The HSP included staff names who can transfer the resident with 1 staff member otherwise the resident needed 2 staff to transfer. Staff should provide assistance with dressing/undressing and personal hygiene/grooming. He/she had a urinary catheter and required 2 staff assistance with toileting needs. Registered nurse (RN) will assess resident and report any change in resident's health status, notify physician and power of attorney. Review of the resident progress notes revealed a typed written sheet identified as a late entry 4/13/18 which included resident information	{S5251}		

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{S5251}	Continued From page 16 between 7/19/17 and 8/14/17 with 2 slash marks on the bottom 3 lines of the progress note. The next page not identified as late entry had information from 5/1/18 through 5/6/18. On 4/14/18 the physician ordered Cipro 250 milligrams (mg) 1 tablet twice a day (BID) for 10 days. There was no evidence in the record of an illness which required physician intervention, or that the resident was monitored for resolution of the illness. The resident progress note next entry after 5/6/18 was dated 5/8/18 at 11:50 AM resident arriving home today. received call from case manager asking about transportation. Advised him/her licensed nurse/operator E would call for transportation company to transport the resident with discharge set at 2:00 PM. Record review on 5/14/18 at 1:45 PM revealed no other progress notes in the resident's record. At 2:22 PM the surveyor asked licensed nurse/operator E if there were any other progress notes about the hospital return or since 5/8/18 he/she said "I think I was writing that today when you came in". He/she provided a hand written progress note dated 5/14/18 at 9:20 AM which read "resident arrived at home at 1430 (2:30 PM) per transportation company - per wheelchair. Resident appeared to be happy to be home. Bandage on Left arm, apparently from IV (intravenous) site used at hospital. Bruises noted on right hand also" The progress note was not signed and included no other information. The note was not identified as a late entry or that the return to home occurred on 5/8/18. There were no other notes regarding monitoring of the resident's condition post return from hospitalization to ensure there was no relapse of illness which caused the hospitalization.	{S5251}		

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{S5251}	Continued From page 17 On 5/15/18 at 10:11 AM licensed nurse/operator E provided the physician order for the Cipro which was dated 4/14/18 and had not been in the record during review on 5/14/18 at 1:45 PM. He/she confirmed the note about the resident's hospital return was not made until 5/14/18. Licensed nurse/operator E failed to ensure resident #1201's record included 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. - Record review for resident #1202 revealed an admission date of 12/27/17 with diagnoses of atrial fibrillation, generalized muscle weakness, hypertension and type 2 diabetes mellitus. The admission Functional Capacity Screen (FCS) dated 12/27/17 indicated the resident required physical assistance with bathing, dressing, toileting, transfers, walking and mobility. His/her cognition was not scored and interview with licensed nurse/operator E on 5/14/18 at 12:30 PM revealed the resident had long-term memory impairment, memory recall impairment and impaired decision making. The Negotiated Service Agreement dated 12/27/17 indicated the facility would provide the resident with physical assistance of 1 staff for activities of daily living (ADLs) such as bathing, toileting, dressing/undressing, personal hygiene/grooming and transfers. Licensed nurse/operator E would be responsible for supervised nursing services. The Health Service Plan (HSP)/care plan dated	{S5251}		

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{S5251}	Continued From page 18 12/27/17 directed staff to provide physical assistance of 1 staff for ADLs. Resident will receive medical treatment at facility from medical director. Registered nurse (RN) is responsible for obtaining physician orders and sending new orders to pharmacy. CMAs/RN will be responsible for administration after proper training/education. RN will assess resident and report any change in resident's health status, notify physician and power of attorney. Review of the resident progress notes revealed an entry dated 4/24/18 at 2:54 PM indicating on 4/19/18 the resident had an appointment with an orthopedic physician. The next entry was dated 4/24/18 at 3:00 PM resident continues on Cipro acting much less confused since starting on antibiotic. Previous progress notes lacked any information about the resident's illness which resulted in him/her needing treatment with an antibiotic. The next and last entry was dated 4/24/18 at 3:20 PM regarding tuberculosis testing. The last half of the page was blank with 11 lines available for documentation. When surveyor asked about the entry of continuing on Cipro licensed nurse/operator E provided another page of resident progress notes which were dated 5/14/18 at 12:30 PM. The note read "[resident's name] had been exhibiting signs of confusion, spoke with .../power of attorney he/she stated resident was either dehydrated or had UTI. Notified physician that I had done a UA on resident due to confusion on 4/14/18 at 9:56 AM Culture showed Cipro as drug of choice - order for Cipro 250 milligrams twice a day for 10 days. meds ordered, received and given per order. UA at end of treatment was negative for UTI". Interview on 5/14/18 at 12:56 PM with licensed nurse/operator E revealed the reason for the	{S5251}		

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{S5251}	Continued From page 19	{S5251}		

Cipro was a urinary tract infection (UTI). When asked about the documentation about the illness and the reason for the Cipro he/she provided evidence of text messaging on his/her cell phone indicating on 4/14/18 at 9:56 AM the physician ordered Cipro 250 mg twice a day for 10 days.

Licensed nurse/operator E failed to ensure resident #1202's record included 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.

- Record review revealed resident #1203 admitted to the facility on 7/1/11. His/her diagnoses included: abdominal mass, splenomegaly, hypertension, fluid retention and incontinent episodes.

The annual Functional Capacity Screen dated 8/5/17 indicated the resident needed physical assistance with toileting, transfers, dressing and mobility. He/she experienced total urinary incontinence and was cognitively impaired with impaired decision making.

The Negotiated Service Agreement (NSA) dated 8/5/17 indicated the resident was unable to dress/undress him/herself, unable to toilet self and required 2 staff to transfer him/her on and off the toilet and required staff assist with personal hygiene needs and managing incontinence. The resident used a wheelchair for mobility and required 1 staff to move the wheelchair.

The Health Service Plan (HSP)/care plan dated 8/5/17 directed staff to provide 1 staff assist for the resident with mobility and use of wheelchair, he/she is unable to self-transfer and required

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{S5251}	Continued From page 20	{S5251}		

assistance of 2 staff. The resident was unable to feed him/herself and required staff to feed him/her, staff needed to dress/undress the resident and to assist with all hygiene and grooming needs for the resident. The resident required the assistance of 2 staff to transfer from the wheelchair to the toilet and back to the wheelchair. During the hours of sleep (HS) staff will check and change the resident's incontinence as needed. The RN will assess resident and report any changes in resident's health status, notify physician and power of attorney.

The resident roster provided by licensed nurse/operator E on 5/14/18 at 12:30 PM revealed the resident had a skin condition. When asked to explain the skin condition he/she reported the resident had a pressure ulcer on the bottom.

Review of the resident progress notes revealed the last entry dated 1/11/18 by the resident's physician which did not included any information about the resident's buttocks. The notes prior to that note were dated 3/9/17 through 9/27/17. The record lacked any evidence of a nurse assessment regarding the resident's change in health status or notification of the physician regarding the skin condition.

Review of the physician orders revealed on 4/12/18 mobile X-ray preformed an X-ray of the resident's right wrist for swelling and bruising. The resident progress notes lacked any information about the change in health status.

Interview on 5/14/18 at 12:33 PM licensed nurse/operator E said he/she knew the record lacked information about the pressure ulcer.

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{S5251}	Continued From page 21 Licensed nurse/operator E failed to ensure resident #1203's record included 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. - Record review for resident #1204 revealed an admission date of 2/11/11 with diagnoses of chronic obstructive pulmonary disease (COPD), urinary tract infection (UTI), anxiety and pain. The annual Functional Capacity Screen (FCS) dated 3/5/18 indicated the resident needed physical assist with activities of daily living (ADLs) such as bathing, dressing/undressing, toileting, transfers, walking/mobility and eating. He/she had short and long-term memory deficit, memory recall deficit and impaired decision making. The Negotiated Service Agreement (NSA) dated 3/5/18 included for staff to provide physical assistance of 1 staff for ADLs as listed in FCS. The NSA indicated licensed nurse/operator E would be responsible for supervised nursing services. The NSA listed risk factors for pressure wound which included: immobility, altered mental status, dry skin, previous pressure wounds, edema, incontinence, malnutrition, dehydration, significant weight loss, resident not being turned, age 70 and older and multiple other factors. Under Assessing, treating and managing pressure wounds - Registered nurse (RN) will assess, treat and manage pressure wounds per physician orders and standard care of nursing; delegating duties to educated certified staff per regulations, ensuring education requirement have been met. Certified medication aides (CMAs) and/or RN will administer all physician ordered medications and treatments.	{S5251}		

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{S5251}	Continued From page 22 The Health Service Plan (HSP)/care plan dated 3/5/18 directed staff to provide physical assistance with ADLs as listed in FCS. The resident will receive medical treatment at the facility from medical director. RN is responsible for obtaining physician orders and sending new orders to the pharmacy. RN will assess resident and report any change in resident's health status, notify physician and power of attorney. The resident roster provided by licensed nurse/operator E on 5/14/18 at 12:30 PM revealed the resident had a skin condition. When asked to explain the skin condition he/she reported the resident had a pressure ulcer on the bottom. Review of the physician orders and medication administration record (MAR) for April 2018 revealed a hand written direction without a date for dressing change on bottom every 3 days or as needed. On 4/29/18 the physician ordered Rocephin 1 gram intramuscularly (IM) for 5 days for UTI. The resident also had an order for Risamine ointment apply thin layer on affecter layer 2-4 times daily or after each incontinent episode as needed (PRN) until healed since 1/10/18 with no documentation of application. Review of the physician orders and MAR for May 2018 revealed the same orders as April 2018. Licensed nurse/operator E reported on 5/14/18 at about 1:30 PM the resident needed an injection of Rocephin. The record had no order written within it and the May 2018 MAR did not include an order for Rocephin other than the previous April order. Review of lab results revealed on 4/27/18 the facility sent a urine specimen to the lab for	{S5251}		

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{S5251}	Continued From page 23	{S5251}		

analysis with results of E-Coli bacteria with susceptibility to Rocephin (ceftriaxone). On 5/9/18 the facility sent a urine specimen to the lab for analysis with results of E-coli bacteria which was susceptible to Rocephin.

Review of the resident progress notes revealed a full page of documentation ranging from 3/14/17 at 6:15 PM to 3/23 (no year) and no time. The next page had an entry dated 5/1/17 at 3:50 AM which took 5 lines of the page leaving 20 lines blank.

Observation on 5/14/18 at 2:00 PM revealed 5 vials of Rocephin filled on 5/14/18 were in the medication room.

Observation on 5/14/18 at 2:05 PM revealed certified medication aide (CMA) A and CMA B assisted the resident to transfer from the recliner to a wheelchair and then to the toilet. The resident was incontinent of loose bowel movement. There was no dressing in place on his/her bottom. After perineal cleansing observation revealed both sides of the resident's buttock at the gluteal crease were a darker pink than surrounding skin, had top layer of skin peeling off and scar tissue evidence of previous open areas.

Interview on 5/14/18 at 3:40 PM with licensed nurse/operator E revealed he/she was aware the documentation was not current and did not reflect conditions, physician orders and treatments being administered.

Licensed nurse/operator E failed to ensure resident #1204's record included documentation of all incidents, symptoms and other indications of illness or injury including the date, time of

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{S5251}	Continued From page 24 occurrence, action taken and results of the action.	{S5251}		
{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)(3) The facility census totaled 6 residents. Based on interview and record review licensed nurse/operator E failed to have evidence the registry was checked prior to working for 1 of 3	{S5258}		

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{S5258}	Continued From page 25 newly hired direct care providers (certified medication aide B). Findings included: - The facility provided a list of 3 employees hired since last resurvey review. All 3 were certified medication aides (CMA). Review of the personnel records on 5/15/18 at 11:20 AM revealed the records lacked evidence of the facility checking with the registry before CMA B began providing care on 4/18/18. During and interview on 5/15/18 at 11:50 AM with licensed nurse/operator E confirmed the personnel record for CMA B lacked evidence of registry verification. He/she said the folder which included the document was lost. He/she confirmed CMA B first day on duty was 4/18/18. Licensed nurse/operator E failed to have evidence the registry was checked prior to working for CMA B.	{S5258}		
{S5313} SS=E	26-42-205 (g) (3) Over the counter medication (g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and	{S5313}		

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{S5313}	Continued From page 26 the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of 6 residents. Based on observation and interview for all residents receiving facility management of medications, licensed nurse/operator E failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication packages or containers. Findings included: - The resident roster identified 6 residents received facility management of medications. Observation revealed on 5/14/18 at 4:11 PM certified medication staff B unlocked the only medication cart which contained opened over the counter (OTC) medication bottles stored in several of the cart drawers. In the top drawer there were 3 bottles of Miconazole-Zeasorb AF (antifungal) athletes foot powder. One of the bottles had a type written white label with the first and last name of resident #1201 and the other 2 bottles beside it had no name. In the second drawer was Gentlelax with resident #1202's first name on the bottle and a portion of the first name on the bottle cap. In the bottom drawer was the following OTCs labeled with resident #1201's first name only: a 13 ounce jar of petroleum jelly, tube of thick moisture barrier paste and chloroseptic sore throat lozenges. There were 6 packages of various flavored cough drops without a resident's	{S5313}		

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 05/17/2018

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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{S5313}	Continued From page 27 name. During interview on 5/15/18 at 10:38 AM with licensed nurse/operator E confirmed the OTC medications should be labeled with the first and last name of the resident. On 5/15/18 at 10:38 AM a request for the facility's policy regarding OTC medications resulted in no policy provided and review of the facility's policy and procedure notebook available for staff revealed no policy for OTC medications. For all residents receiving facility management of medications, licensed nurse/operator E failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each OTC medication package or container.	{S5313}		