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	B087196	A. BUILDING: _____ B. WING _____	05/07/2018

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PEACE OF MIND LLC II	223 N BURR OAK ROAD, PO BOX 173 WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of a licensure resurvey for the above named facility with complaint investigation #124558 on 5/2/18, 5/3/18 and 5/7/18.	S 000		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of 6 residents. The sample included 3 residents and 3 focused closed record reviews. Based on record review and interview the operator failed to ensure a revision of the Negotiated Service Agreement following a significant change in condition for 1 of 6 residents sampled (#604). Findings included: - Record review for resident #604 revealed the	S5116		

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

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resident admitted to the facility on 11/17/17 with diagnoses of: Alzheimer's disease, mood disorder, type 2 diabetes mellitus, obesity, atrial fibrillation and hypertriglyceridemia.

The admission Functional Capacity Screen (FCS) dated 11/17/17 indicated the resident was unable to perform the tasks of bathing, dressing, toileting, transfers or walk/mobility. The resident was usually continent of bladder had impaired decision making and inappropriate behaviors.

The Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 11/17/17 directed staff to provide 3 meals a day with snacks, medication management, total assistance with bathing, dressing/undressing, physical assistance of 2 staff for toileting, was incontinent and required 2 staff assist with transfers (the NSA had Hoyer with a date of 12/18/17 added without initials of all parties. Hoyer is a brand of total body mechanical lift). The NSA indicated the resident needed behavior management which listed re-direct as the only intervention. The page for Addendums was blank.

Review of the nursing notes revealed the resident came from a behavioral unit on 11/17/17 at 4:00 PM and admitted to the facility. On 11/20/17 at 2:00 PM the resident displayed confusion with mumbling speech and physical aggressive behavior towards staff during activities of daily living (ADL) cares. He/she required extensive assist of 2 staff to toilet and was difficult to redirect, required frequent visual monitoring for safety and was noted to attempt to get up without assistance. While staff was putting his/her socks on he/she kicked the staff in the face. On 11/21/17 at 12:01 AM the resident was up most of the night, very confused, unable to redirect, as

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needed (PRN) medications given without results, he/she pulled handles off furniture, throwing items, physical aggression towards staff and hit a staff with a closed fist in the face. He/she continuously propelled him/herself throughout the house and required close visual monitoring for safety due to impulsiveness with getting up from the wheelchair without staff assistance. After obtaining physician orders the resident was transported to a behavior unit for a direct admitted on 11/21/17 at 10:00 AM for dementia, physical and verbal aggression.

On 12/18/17 the facility received orders to Re-admit the resident. The discharge instructions identified the resident as alert with somnolence at times, cooperative, required a Hoyer lift, wheelchair, assistance, turning every 2 hours for a pressure ulcer and had a urinary catheter for retention. The discharge instructions referred to the crisis prevention plan.

The crisis prevention plan with a revision date of 12/15/17 indicated the resident has assaultive behaviors with triggers of not being listened to, loud noises, arguments, chattering that doesn't stop and not having control. Warnings signs included not being able to sit still, loud voice, swearing and agitation. Strategies to calm down and keep safe included: time away in his/her room, coloring, calling family, drawing, reading a book, talking with staff, distractions, paper and pen to write, handy man magazines with suggestions of PVC pipe parts to connect or put together. Family reported the resident likes country music, fixing things, made bird houses and cooking.

The FCS dated 12/18/17 indicated the resident needed physical assistance with bathing,

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dressing and toileting. He/she still required total assistance for transfers, walk/mobility and required a Hoyer lift for transfer to the wheelchair. He/she had a cognition score of 4 indicating impairment with short and long-term memory, memory/recall and decision making. He/she was incontinent of bladder and had socially inappropriate disruptive behavior.

The was no new NSA/HSP following the re-admission or evidence of revision other than the listing of Hoyer lift 12/18/17.

Review of the nursing notes between 12/18/17 at 2:45 PM through 12/21/17 (no time) revealed the resident was very lethargic and semi-alert, unable to fully arouse at times, had signs/symptoms of upper respiratory infection, had a stage 2 pressure ulcer, skin breakdown over the entire buttock with scattered open areas. He/she was unable to bear weight and required a Hoyer lift for transfers. He/she was incontinent of bowel and bladder without any reference to a urinary catheter. The subsequent notes reflected he/she continued to have behaviors of hitting staff with closed fist and being physical combative with ADL cares. On 12/21/17 the resident discharged to another facility.

Interview on 5/3/18 at 12:35 PM with licensed nurse D confirmed the record lacked a new or revised NSA with the readmission to accurately reflect the changes in the resident's condition.

The operator failed to ensure a revision of the Negotiated Service Agreement following a significant change in condition for this resident.

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S5155	Continued From page 4	S5155		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 6 residents. The sample included 3 residents and 3 focused closed record reviews. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement for 1 of 2 residents sampled who fell in past 180 days (#603) and 3 of 3 residents who had side rails attached to the bed (#601, #602 and #603). Findings included: - Record review revealed resident #603 admitted to the facility on 10/24/16 with diagnoses of arthritis, anxiety/agitation, mood disorder, psychotic features and neuropathy (nerve damage usually in the feet). The Functional Capacity Screen (FCS) dated	S5155		

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S5155	Continued From page 5 10/23/17 (did not identify the type) indicated the resident had cognition impairment for short and long-term memory, memory/recall and decision making. The resident required physical assistance with toileting, transfers, walk and mobility. He/she was unable to dress/undress or bath without staff performance. He/she experienced incontinence of the bladder, falls and unsteadiness used a walker and wheelchair. The Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 10/23/17 documented resident used the standard emergency call system and a room monitor for sound (baby monitor style). He/she required total assistance for bathing, dressing/undressing and physical assistance 2 staff with transfers. He/she needed physical assistance toileting, use of a walker and mobility with a wheelchair. Under Health and Wellness monitoring the resident wore glasses as needed, had resistive behaviors and would yell or insult others. Falls/unsteadiness staff wrote assist as needed/recommended with no other interventions listed. Review of the nursing notes from 7/5/17 at 2:00 PM through 4/26/18 (no time) revealed the following accidents/falls: On 8/21/17 at 5:00 AM staff responded to the resident hollering and found him/her half out of the bed on the floor. His/her feet were still in the bed and his/her back was on the floor. The bed rail had come apart in the middle where the rail connected to the top half of the rail which was not in proper placement while the lower half of the rail was in proper placement. The staff were able to place the bed rail back together and secured until family could look in to a different style of bed rail. The note did not include any assessment for	S5155		

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injury by the nurse. The last bed rail assessment was dated 1/4/17 with no other assessments post fall. Review of the NSA/HSP revealed no information regarding the use of a bed rail or interventions for safety related to the malfunctioning bed rail and fall prevention of this type.

On 9/27/17 at 2:00 PM an outside provider planned to deliver a new bed for the resident.

The record lacked information regarding a bed rail assessment of the new bed to ensure the resident was safe to use the bed rail, the bed rail was not a restraint and the bed rail was attached properly to the bed with measurements of the gaps to be less than 4 and 3/4 inches.

On 10/27/17 at 12:30 PM as a nurse approached the doorway of the resident's room he/she noted the resident's wheelchair up against the open doorway and the resident was on his/her buttocks partially leaning against the wheelchair. Staff noted the resident's jacket was on 1 arm and believed the resident was leaning/moving in the wheelchair to put the jacket on. The nurse assessed for injuries with no new injuries noted, assisted back into the wheelchair and taken to lunch. Staff hung the jacket back in the resident's closet. The nurse notified the physician who ordered lab work based on the recent decline in his/her condition.

The NSA/HSP lacked any information about this fall or interventions to prevent further falls.

On 11/7/17 at 5:30 PM staff heard the resident yelling for help. Staff found the resident in his/her room on the floor with his/her legs bent, right arm at his/her side and left arm still sitting up on the

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bed. The resident stated he/she was looking for his/her family member and calling out for the family member. The nurse assessed the resident without injury. The resident was last seen by staff when placed in bed 2 hours prior to the time of the fall. The resident was incontinent of bowel and bladder. The bed rails were up at the time of the fall and resident had used the rails to sit him/herself up in the bed. Frequent visual checks were performed (but did not specify how frequent for how long).

The NSA/HSP did not include any information about this fall or interventions to prevent further falls.

Review of the facility's Fall investigations for the above falls revealed no additional information for interventions to prevent future falls.

Observation on 5/3/18 at 8:38 AM revealed the resident had a quarter sized bed rail in the upright position on one side of the bed and the other side of the bed also had a bed rail which was down with the bed against the wall.

Interview on 5/3/18 at 10:50 AM with licensed nurse D confirmed the neither the fall investigations, nursing notes or NSA/HSP included new interventions to prevent falls with each fall the resident had as listed above.

The facility's bed rail policy without a date directed a licensed nurse would assess the resident upon admission, quarterly (if bed rails are used) and with a significant change in condition to determine if the bed rails are appropriate. An assessment of the resident's ability to safely use the bed rail and assessment of the safety of the bed rail device will be

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documented in the resident's record. The use of the bed rail and the purpose of the bed rail will be documented in the NSA/HSP.

The operator failed to ensure a licensed nurse assessed this resident related to bed rail use and failed to develop/coordinate serviced needed and to prevent falls.

- Record review of resident #601 revealed an admission date of 3/27/18 with diagnoses of: depression, development delay, osteoporosis, seizure disorder and falls.

The admission Functional Capacity Screen (FCS) dated 3/27/18 indicated the resident had a cognition score of 4 with impaired short and long-term memory, memory/recall and decision making. The resident needed physical assistance with bathing, dressing, toileting and supervision with transfers and walking.

The Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 3/27/18 indicated staff would provide partial assistance for bathing and dressing, physical assistance with toileting and transfers with supervision for mobility walking short distances. He/she had falls and unsteadiness with nothing indicated as interventions to prevent further falls. The NSA/HSP did not include information about bed rails use.

The record lacked any assessment for bed rail use.

Observation on 5/3/18 at 8:40 AM revealed the resident's bed had a quarter sized rail attached on both sides of his/her bed which could be raised to the upright position.

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S5155	Continued From page 9 Interview on 5/3/18 at 10:50 AM licensed nurse D confirmed the resident had bed rails attached to the bed, the record lacked an assessment of the bed rails and the NSA/HSP did not include the use of bed rails. The facility's bed rail policy without a date directed a licensed nurse would assess the resident upon admission, quarterly (if bed rails are used) and with a significant change in condition to determine if the bed rails are appropriate. An assessment of the resident's ability to safely use the bed rail and assessment of the safety of the bed rail device will be documented in the resident's record. The use of the bed rail and the purpose of the bed rail will be documented in the NSA/HSP. The operator failed to ensure a licensed nurse assessed this resident related to bed rail use and failed to include the bed rail use on the NSA/HSP to coordinate services needed for this resident. - Record review revealed resident #602 admitted on 3/20/18 with diagnoses of weakness, cognitive/communication deficit, repeated falls and diabetes mellitus. The Functional Capacity Screen (FCS) dated 3/20/18 (without specified type) indicated the resident had a cognition score of 4 with impaired short and long-term memory, memory/recall and decision making. He/she needed physical assistance with bathing, dressing, transfers, walking and mobility. He/she had a history of falls/unsteadiness. The record had a use of bed rail assessment without a date or signature of nurse completing	S5155		

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the assessment. It indicated the resident could use a quarter rail.

The Negotiated Service Agreement (NSA)/Health Service Plan (HSP) dated 3/20/18 included the resident needed physical assist with toileting, transfers, mobility and had cognitive impairment. The NSA/HSP included 1/4 side rail left side.

Observation on 5/3/18 at 8:53 AM revealed the resident's bed had a quarter rail on both sides which were in the upright position.

Interview with certified medication aide (CMA) A on 5/3/18 at 8:53 AM revealed the resident used the rails to turn him/herself side to side and when getting in/out of the bed. He/she said before the rails were on the bed the resident would plop down on the bed.

Interview on 5/3/18 at 10:50 AM licensed nurse D confirmed the resident had bed rails attached to the bed, the assessment lacked a date and signature of completion and the NSA/HSP did not match the actual use of bilateral rails.

The facility's bed rail policy without a date directed a licensed nurse would assess the resident upon admission, quarterly (if bed rails are used) and with a significant change in condition to determine if the bed rails are appropriate. An assessment of the resident's ability to safely use the bed rail and assessment of the safety of the bed rail device will be documented in the resident's record. The use of the bed rail and the purpose of the bed rail will be documented in the NSA/HSP.

The operator failed to ensure a licensed nurse assessed this resident related to bed rail use and

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S5155	Continued From page 11 failed to accurately reflect the bed rail use on the NSA/HSP to coordinate services needed for this resident.	S5155		
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; 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)(4) The facility reported a census of 6. The sample included 3 residents and 3 focused closed record reviews. Based on interview and record review the operator failed to ensure the residents could be evacuated to a secure location with the least amount of staff on duty at any time. The operator also failed to ensure residents and staff received quarterly review of the facility's emergency management plan.	S5215		

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S5215	Continued From page 12 Findings included: - On 5/2/18 a request was made to review the last 2 annual fire evacuations of the residents to a secure location. The facility could not provide evidence of an evacuation for 2016 or 2017. The 2018 documents of evacuation revealed on 2/16/18 (no specified time of day) 2 staff evacuate residents (no specified # of residents on that date and time) and did not indicate where the residents were evacuated too. The document included a time of 3 minutes. Another document titled Fire Drill Record had a date of 2/16/18 at 1:45 (does not say a.m. or p.m.) with 6 residents evacuated (did not indicated where evacuated) and did not included how many staff participated. The documents inlcuded other evacuations which also lacked date, time (including a.m. or p.m.), how many residents evacuated, where they were taken, how many staff participated in the drill and the length of time required for the evacuation. Interview on 5/3/18 at 11:50 AM with operator E confirmed the facility lacked evidence of fire drill evacuations for 2016 and 2017. He/she confirmed the documents provided were not clear in the time of day the drill was conducted, how many residents participated, where the residents were evacuated to, how many staff did the evacuation and how long it took to evacuate. The operator provided a notebook with 32 loose pages clipped together. These documents included 5 pages which were unlabled or dated that included staff names and/or resident names. The remaining pages inlcuded a titled of Natural Disaster's Quarterly Training In-service which included Fire, Tornado, Explosions/natural gas leak, Loss of electricity, Loss of water, Flood and Natural diasters. The title pages sometimes had	S5215		

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S5215	Continued From page 13 dates or would just list the month and year. At the bottom of these pages was a place for staff to print their name and signature the next page was for residents (which did not include a date or identification of what the page meant). The following represents the documentation reviewed: 8/12/16 with 5 staff listed and unable to determine how many residents participated. November 2016 with 5 staff listed and 7 residents (this page was not dated and was loose in the notebook) Jan 2017 listed 1 staff and 1 resident (date after name of 1/19/17) 2-2017 with 7 staff and 7 residents (2 of the resident names had dates after them of 2-17-17 and 2-28-17) 5/19/17 with 11 staff and 8 residents (1 resident had 6/08/17 as a date) 6/16/17 was titled Addendum employee in-service 6/16/17 Emergency Preparedness and asked staff to sign to confirm the resident elopement was part of the May emergency preaparedness meeting. This included 4 staff names. June 2017 listed 1 staff and 1 resident (dated 6/8/17) August 2017 with 11 staff and 10 residents (3 residents had dates behind their names of 9/22/17, 10/2/17 and 10/20/17) October 2017 lsited 1 staff and 2 residents (10/20/17 and 10/21/17) November 2017 with 4 staff and 10 residents December 2017 listed 1 staff and 2 residents (12/20/17 and 12/26/17) Jan 2018 listed 1 staff and 1 resident (1-4-18) February 2018 with 6 staff and 7 residents (1 had a date after the name of 3/20/18) The facility also provided an Annual Disaster and Emergency Preparedness evacuation and drill dated 1/15/18 which included 9 staff and 8	S5215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087196	A. BUILDING: _____ B. WING _____	05/07/2018

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S5215	Continued From page 14 residents with an evacuation time listed of 3 minutes and 20 seconds but did not include the time of day and if all 9 staff participated or where evacuated to. During an interview at 11:50 AM on 5/3/18, operator E confirmed the documents provided were not clear of when the disaster training took place related to date and time. The documents were not clear as to how many staff and residents participated because the signature sheets were not dated and staff lined up the pages as best as they could. He/she reported a total of 10 staff for the facility at this time and some of the trainings did not include all staff. The operator failed to ensure the residents could be evacuated to a secure location with the least amount of staff on duty at any time. The operator also failed to ensure residents and staff received quarterly review of the facility's emergency management plan.	S5215		
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 the medication container.	S5313		

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S5313	Continued From page 15 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(3) The facility reported a census of 6 residents. The sample included 3 residents and 3 focused closed record reviews. Based on observation, and interview for all residents receiving facility management of medications, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on each over-the-counter (OTC) medication package or container. Findings included: - The resident roster identified 6 residents received facility management of medications. On 5/2/18 at 4:02 PM certified medication aide (CMA) B opened the only medication cart. Observation revealed the following over the counter (OTC) medications labeled as "Stock" and not for an individual resident: Glucosamine Chrondroition complex 1500 milligrams (mg) Aspirin 81 mg Acetaminophen 500 mg Milk of Magnesia 2 bottles Polyethylene Glycol Interview on 5/2/18 at 4:04 PM with licensed nurse D revealed he/she did not know OTC medications were for single resident use only and must be labeled by a licensed nurse or pharmacist with the resident's full name. The operator failed to ensure a licensed nurse or	S5313		

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S5313	Continued From page 16 licensed pharmacist placed the full name of the resident on each OTC medication package or container.	S5313		