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	N087083	A. BUILDING: _____ B. WING _____	R-C 02/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDER'S CREST, LLC	6887 E ROCKHILL STREET WICHITA, KS 67206

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{S 000}	INITIAL COMMENTS The following citations are the result of a revisit and notice of assessment visit #17-126 at the above named Residential Health Care Facility in Wichita, Kansas on 02/12/18, 02/13/18, 02/14/18, 02/15/18, 02/19/18, 02/20/18, 02/21/18, 02/22/18, and 02/26/18. Complaint #125994 also investigated.	{S 000}		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The census equaled 26 current Residents and two discharged Residents. The sample included three Residents and one focused review. Based on observations, interviews, and record reviews, for one of three sampled (#1030), the Operator failed to ensure no Resident was subjected to neglect when staff failed to follow facility policy and the resident's care plan and transferred resident #1030 using a sit to stand lift with one staff person instead of 2 as specified in the policy and care plan. Resident #1030's foot slipped forward off the lift and he/she was lowered to the floor, resulting in a fracture of thoracic vertebrae	S3026		

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

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number 10.

Findings included:

- Record review revealed #1030 admitted to facility 7/29/17 with diagnoses of atrial fibrillation, congestive heart failure, edema, anemia, depression, gastroesophageal reflux disease, and hypertension.

7/29/17 functional capacity screen (FCS) completed by facility nurse #F assessed #1030 in need of physical assistance with bathing, dressing, toileting, transfer (use sit to stand lift) and independent with mobility (uses electric wheelchair). The resident had impaired short-term memory, memory recall, and decision making; and used a wheelchair and mechanical lift used.

7/29/17 NSA completed by facility nurse #F documented a standardized list of services to be provided by facility staff.

7/29/17 health care services plan (HSP) section titled "ambulation" recorded "uses wheelchair... Resident is an assist of 2 to transfer (using lift) to electric wheelchair"; is oriented to person and at times place and time; able to communicate want and needs verbally, verbally understands others and follows directions. In an emergency "Resident can transfer into electric wheelchair with assist of 2 and a lift and can exit the building independently with cuing from staff." The HSP was completed by facility nurse #F and Operator #A.

Nurses Notes (NN) of record included:

01/06/18 - 4:20pm - by facility nurse #C - "staff

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S3026	Continued From page 2	S3026		

transferring Resident to bathroom using sit to stand lift, Resident's right foot slipped off of lift scraping right shin reopening an old wound. Staff lowered Resident onto the floor to adjust him/her back onto the lift, and transferred back into chair. Resident denies pain, passive range of motion to all extremities without difficulty, right shin area with abrasions noted, skin not present to area and no active bleeding noted, cleansed with normal saline, applied triple antibiotic ointment, covered with mepilex dressing. . Faxed communication to medical provider . . left voicemail for family member." (Review of fax to medical provider revealed sent fax at 5:18pm)

01/06/18 - 10:59pm - by facility nurse #C - "at 2000 [8 pm] Resident spoke with family on the phone, family called this writer back about incident that happened earlier on the lift, Resident told family that Resident reports he/she broke his/her back and wants to go to the hospital, explained to family that this nurse came out to assess Resident and Resident had good range of motion and denies pain, Resident's family states it is OK for him/her to go since he/she thinks something is wrong, called APRN (advanced practice registered nurse) #B and received order to send to hospital for evaluation and treatment... called EMS (emergency medical service) and Resident was transported to hospital at 2115 [915pm]. All paperwork sent with EMS to the hospital."

The next and final NN entry of the record:

01/30/18 - 1:00pm - by facility nurse #F - this nurse received a phone call from Resident's family... states that Resident will remain at new

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facility (there for rehabilitation after hospitalization) due to recent change in condition and noncompliance with PT/OT (physical therapy/occupational therapy). Family states that Resident is currently refusing to get out of bed and believes that care will be too much for this facility staff to handle. This nurse went to visit the Resident and agrees care needs supersede the ability of this facility (numerous skilled needs) and a skilled unit might be more appropriate for Resident."

The January 2017 MAR (medication administration record) documented #1030 received Hydrocodone (narcotic pain medication for pain at 7/10) and Ativan (anti-anxiety medication for anxiety at 8/10) at 5:00pm on 01/06/18.

Hospital history and physical dated 01/07/18 recorded: "...status post fall from lift device. The patient reports was being transferred to a lift device when feet slipped out from under and he/she began to slip. Staff at his/her facility was attempting to help, however he/she continued to slip and fell backwards landing on lower back and buttock. He/she reports feeling a "crack in middle back" as he/she fell denies hitting head and denies any loss of consciousness... found to have thoracic spine fractures.. further evaluated and admitted to the trauma service."

Radiology:"CT (computerized tomography) of the thoracic and lumbar spine reveals acute T10 fracture with distraction of superior and inferior fragments with a history of a chronic T10 fracture present on CT from September 2016".

On 02/14/18 at 1:45pm, business office manager

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#J provided copy of incident report that documented:
Person initiating form: certified staff #D
Date/Time of incident: 01/06/18 at 2:39pm
Location: Bathroom
Description of Incident: #1030 was going to bathroom his/her feet slipped of the sit to stand lift unable to keep standing staff assist him/her down to the floor where we notice and old skin tear opened back up
Witness(es): certified staff #D
Nature of injury: Re-opened old wound to right shin area
Follow-up action and notification for nursing to complete: (no time) "re-opened old wound to right shin area - cleansed with normal saline - applied triple antibiotic ointment - covered with mepilex dressing. passive range of motion to all extremities without difficulty. denies pain at this time. Faxed communication to medical provider (no time), left voice mail for family (no time), notified Operator #A via report (no time)."

The incident report lacked identification of the staff involved in the incident.

Written statement by #D on 02/15/18 documented "The resident (#1030) rang bell around 2:30pm. He/she needed to go to the bathroom. [Certified staff # D] and certified [staff # Q in his/her room]. I [staff D] hooked him/her up to the lift so then we asked the resident if he/she was ready. As I [staff D] start to pull the lift toward bathroom the resident says my foot has slipped. This is when [certified staff #D and #Q] told him/her [the resident] we'd count to three and lift back on the lift while he/she pushed up. After the three count we raised his/her foot up but [the resident] let body go limp stating he/she just can't do it. Certified staff #Q went to get certified staff

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#E and #S to come in to assist. We decided to let #1030 down to the floor and just all help put him/her back in the chair. This is when we got certified staff #U because we were getting all the [staff] who were strong enough to support getting #1030 up off the floor."

Written statement by #Q on 02/15/18 documented "I was in the hallway charting when a [staff D] called me into Resident #1030's room because his/her foot had slipped off the lift. We both tried putting [the resident's] feet back on the lift and couldn't so we called for help and two other aides came in to help lower to the floor and then we lifted him/her into his/her chair. There was a med-aide there to assess him/her before getting him/her off the floor."

By interview on 02/15/18 at 9:20am certified staff #E stated "an aide was transferring #1030 and his/her foot slid off the lift so all of us lowered him/her to the floor and got in the wheelchair. He/she stated facility nurse #C had just left to go to another facility and came back later. #1030 did not complain of pain initially but after a while complained about something in his/her back"

On 02/15/18 facility nurse #C provided written statement that he/she was the on-call nurse at facility 01/06/18 and received a call from facility around 2:45pm. Staff reported #1030 re-opened old wound on leg when using the lift. "I had actually just arrived at the building while I was talking to staff. I went to #1030's room and staff explained that while transferring the resident with sit to stand lift, [his/her] right leg slipped forward off the lift and he/she was unable to lift foot back onto lift, and both staff lowered [him/her] to the floor, adjusted legs back onto the lift and then

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lifted him/her back up. Staff reports that is when they noticed the open area on [his/her] leg. I assessed #1030 at that time. [He/she] had no complaint of pain, range of motion was good to all extremities and no other visual injuries except the opening on his/her right leg."

On 02/14/18 at 10:30am interview with resident #1030 stated he/she used a sit to stand lift at facility... "always two people in the morning... during the day or if understaffed would use one person to transfer me... on day of the accident at around 3:00pm. I called for help to the bathroom. He/she [provided a description of certified staff D] had helped me before. I think they didn't have anyone else to help him/her that day. It was about time to get the others up for supper. It was just this [staff] and no one else in the room. He/she didn't do anything different. I had on a new pair of athletic socks, felt my feet slipping and told [staff] that . .. I was holding on for dear life - about half way down I felt something in my back pop." #1030 described how additional staff came in room; lowered him/her to the floor and then two or three of them picked #1030 up and put him/her in the wheelchair, took him/her to the recliner and used the lift to get #1030 in the recliner. #1030 continued, stating staff provided first aid to the scrap on his/her leg that occurred during the incident. Resident #1030 further stated "I called my family about supper time and then I went to the hospital straight from my recliner... [at the hospital] they told me I had a broken whatever number it was in my back and also saw an old one from when I had fallen on the ice one time years ago... they wouldn't do surgery because I am too old. I was in the hospital four to five days."

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S3026	Continued From page 7 By interview on 02/12/18 at 8:00pm, family member of #1030 stated Resident "called me on 01/06/18 at about 4:00 or 4:30pm... told me one person came to transfer to bathroom and lowered to floor after foot slipped then gravity pulling him/her down... felt a pop in back and pain... I suggested 'see if you can have some pain medication'. He/she called me back about 8:00pm and said he/she was hurting really bad need to go to hospital. . . .The tests showed T10 (10th vertebrae of the thoracic or upper back spine) compression fracture." By review of facility policy and procedure for Mechanical Lifts: "4. Care staff will ensure they have 2 Care Givers actively engaged in Resident's transfer while Resident in utilizing any mechanical lift." The Operator failed to ensure #1030 not subjected to neglect when staff failed to follow facility policy and the care plan that specified two staff present for all transfers of Residents with lifts. When one staff was transferring #1030 using the lift, his/her foot slipped, staff lowered him/her to the floor and #1030 experienced a fracture of the thoracic spine.	S3026		
S3028 SS=D	26-41-101 (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 facility 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:	S3028		

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S3028	Continued From page 8 (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (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 26-41-101(f)(3)(A)(B)(C)(D)(E)(F) The census equaled 26 current Residents and two discharged Residents. The sample included three Residents and one focused review. Based on interviews and reviews of record, for one of three sampled (#1030) who reported missing personal belongings and who experienced a fracture in upper back during transfer with a sit to stand lift the Operator failed to ensure each allegation of potential abuse, neglect and exploitation was reported to the department and thoroughly investigated.	S3028		

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S3028	Continued From page 9 Findings included: - Record review revealed #1030 admitted to facility 7/29/17 with diagnoses of atrial fibrillation, congestive heart failure, edema, anemia, depression, gastroesophageal reflux disease, and hypertension. 7/29/17 functional capacity screen (FCS) completed by facility nurse #F assessed #1030 in need of physical assistance with bathing, dressing, toileting, transfer (use sit to stand lift) and independent with mobility (uses electric wheelchair). The resident had impaired short-term memory, memory recall, and decision making; and used a wheelchair and mechanical lift used. 7/29/17 NSA completed by facility nurse #F documented a standardized list of services to be provided by facility staff. 7/29/17 health care services plan (HSP) section titled "ambulation" recorded "uses wheelchair... Resident is an assist of 2 to transfer (using lift) to electric wheelchair"; is oriented to person and at times place and time; able to communicate want and needs verbally, verbally understands others and follows directions. The HSP was completed by facility nurse #F and Operator #A. By review home health plan of care dated 10/06/17 recorded #1030's mental status as "oriented and depressed." On 02/12/18 at 7:56pm family member of #1030 stated he/she had missing items (markers from lift chair side pocket, candy, and pop) between 11/21/17 and 12/16/17. Family member stated	S3028		

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facility nurse #F and owner of company alerted to the missing items... "we were told by facility staff an agency person the perpetrator, wouldn't be working in facility again... items never found or recovered but facility nurse #F and/or owner bought replacement items... later told agency person again working in facility...

On 02/14/18 at 10:30am #1030 described missing items reported to facility staff in November and December 2017. #1030 stated missing items included coloring markers stored in a pocket on recliner, small candy bars, and soda pop. #1030 stated these items reported to facility nurse #F, owner of company, and a family member. #1030 stated the missing items never recovered, but facility nurse #F purchased replacement items before Christmas 2017. #1030 stated facility staff determined "agency staff" the alleged perpetrator, but not aware of how the situation resolved.

By review, Nurses Notes (NN) of record lacked any documentation of reported missing items, or steps taken to investigate or resolve. The medical record lacked evidence this incident reported as an allegation of exploitation to the Department as required.

On 02/13/18 at 2:20pm and 2:23pm facility nurse #F and Operator #A stated no instances that required investigation have occurred related to #1030.
On 02/13/18 at 4:40pm facility nurse #F and Operator #A stated no system for logging of lost/stolen/missing items... most times things are found... when #1030's markers went missing we bought new ones shortly before Christmas (2017)... also said candy missing, we bought new... pop alleged missing too, don't know that it

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was missing... all kept in bedroom, no camera, no way for us to do more because no time frame and no cameras... we asked staff if anybody saw belongings, no staff determined to be taking belongings... no agency that we know of... no written investigation available...

The Operator failed to ensure each allegation of potential exploitation foe #1030 reported to Department, thoroughly investigated, corrective actions initiated, and a written report maintained by facility.

- By review Nurses Notes (NN) of #1030's record included:

01/06/18 - 4:20pm - by facility nurse #C - "staff transferring Resident to bathroom using sit to stand lift, Resident's right foot slipped off of lift scraping right shin reopening an old wound. Staff lowered Resident onto the floor to adjust him/her back onto the lift, and transferred back into chair. Resident denies pain, passive range of motion to all extremities without difficulty, right shin area with abrasions noted, skin not present to area and no active bleeding noted, cleansed with normal saline, applied triple antibiotic ointment, covered with mepilex dressing. . Faxed communication to medical provider . . left voicemail for family member." (Review of fax to medical provider revealed sent fax at 5:18pm)

01/06/18 - 10:59pm - by facility nurse #C - "at 2000 [8 pm] Resident spoke with family on the phone, family called this writer back about incident that happened earlier on the lift, Resident told family that Resident reports he/she broke his/her back and wants to go to the hospital,

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explained to family that this nurse came out to assess Resident and Resident had good range of motion and denies pain, Resident's family states it is OK for him/her to go since he/she thinks something is wrong, called APRN (advanced practice registered nurse) #B and received order to send to hospital for evaluation and treatment... called EMS (emergency medical service) and Resident was transported to hospital at 2115 [915pm]. All paperwork sent with EMS to the hospital."

The next and final NN entry of the record:

01/30/18 - 1:00pm - by facility nurse #F - this nurse received a phone call from Resident's family... states that Resident will remain at new facility (there for rehabilitation after hospitalization) due to recent change in condition and noncompliance with PT/OT (physical therapy/occupational therapy). Family states that Resident is currently refusing to get out of bed and believes that care will be too much for this facility staff to handle. This nurse went to visit the Resident and agrees care needs supersede the ability of this facility (numerous skilled needs) and a skilled unit might be more appropriate for Resident."

The January 2017 MAR (medication administration record) documented #1030 received Hydrocodone (narcotic pain medication for pain at 7/10) and Ativan (anti-anxiety medication for anxiety at 8/10) at 5:00pm on 01/06/18.

Hospital history and physical dated 01/07/18 recorded: "...status post fall from lift device. The patient reports was being transferred to a lift device when feet slipped out from under and

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he/she began to slip. Staff at his/her facility was attempting to help, however he/she continued to slip and fell backwards landing on lower back and buttock. He/she reports feeling a "crack in middle back" as he/she fell denies hitting head and denies any loss of consciousness... found to have thoracic spine fractures.. further evaluated and admitted to the trauma service."

Radiology:"CT (computerized tomography) of the thoracic and lumbar spine reveals acute T10 fracture with distraction of superior and inferior fragments with a history of a chronic T10 fracture present on CT from September 2016".

On 02/14/18 at 1:45pm, business office manager #J provided copy of incident report that documented time and date of incident and treatment to open area on leg. The incident report lacked identification of the staff involved in the incident.

Written statements and interviews of direct care staff #D, #Q, #E, and facility nurses #C and #F confirmed an event occurred during transfer of #1030 with a sit to stand lift on 01/06/18... confirmed Resident lowered to floor as he/she began to slip, and was then lifted by staff back up off floor and into chair.

On 02/14/18 at 10:30am interview with resident #1030 stated he/she used a sit to stand lift at facility... "always two people in the morning... during the day or if understaffed would use one person to transfer me... on day of the accident at around 3:00pm. I called for help to the bathroom... #1030 described one staff assisting him/her to the bathroom, foot slipping off lift, then he/she sipping down, additional staff to room to assist all the way to the floor and then staff lifting

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him/her back into the chair... #1030 stated was wearing a new pair of athletic socks... felt a "pop" in back with pain... stated he/she alerted family member to incident and pain and ultimately transferred to hospital for evaluation... testing confirmed a new fracture to the thoracic area of back and also presence of an old similar injury to back...

By interview, family member of #1030 stated Resident "called me on 01/06/18 at about 4:00 or 4:30pm... told me one person came to transfer to bathroom and lowered to floor after foot slipped then gravity pulling him/her down... felt a pop in back and pain... I suggested 'see if you can have some pain medication'. He/she called me back about 8:00pm and said he/she was hurting really bad need to go to hospital. . . .The tests showed T10 (10th vertebrae of the thoracic or upper back spine) compression fracture."

By review of facility policy and procedure for Mechanical Lifts: "4. Care staff will ensure they have 2 Care Givers actively engaged in Resident's transfer while Resident in utilizing any mechanical lift."

On 02/13/18 at 2:20pm and 2:23pm facility nurse #F and Operator #A stated no instances that required investigation have occurred related to #1030... facility nurse #F stated I think foot slipped off... care givers lowered all way to ground... didn't fall so no incident report no investigation completed...

Available documentation failed to present a thorough investigation of the reported incident to rule out abuse or neglect. Confirmed with Department staff no report or investigation of potential abuse or neglect submitted by facility

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S3028	Continued From page 15 staff in regard to missing/stolen/lost items reported by #1030. The Operator failed to ensure each allegation of potential abuse or neglect of #1030 reported to Department as required, thoroughly investigated, corrective actions initiated, and a written report maintained by facility.	S3028		
{S3200} SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The census equaled 26 current Residents and two discharged Residents. The sample included three Residents and one focused review. All	{S3200}		

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Residents identified as receiving medication management. Based on interview and record review for one of three sampled (#1011) and for one focused review (#1013) the Operator failed to ensure all medications and biologicals administered to all Residents in accordance with medical care provider's orders and in accordance with professional standards of practice.

Findings included:

- Review of Resident #1013 medical record revealed he/she admitted to the facility on 7/27/17 with a diagnosis of organic affective disorder, constipation, anxiety and traumatic brain injury.

Review of the Functional Capacity Screen dated 12/6/17 revealed the resident could not manage his/her own medications.

Review of the Negotiated Service Agreement/Health service plan (NSA/HSP) dated 12/6/17 revealed facility staff would administer the Resident's medications. It also directed staff they could crush medications if not contraindicated.

Review of the physician's order sheets dated 10/2/17 included the following orders:
Magnesium Citrate 200 mg 1 tablet daily
Trazodone 100mg 1 tablet at bedtime
Aricept 5 mg 1 tablet daily at bedtime
Flomax 0.4mg 2 capsules daily at bedtime

Review of the January 2018 Medication Administration Record (MAR) staff initialed and circled the following medications with notations as to why the medication was not administered.
Magnesium Citrate 200mg tablet revealed staff circled their initials from 1/1/18 - 1/19/18 with a notation "med not available".

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Trazodone 100mg tablet revealed staff circled their initials on 1/5,6,7/18 with a notation "waiting on pharmacy".
Aricept 5 mg tablet revealed staff circled their initials on 1/1/18 and 1/6/18 with a notation "waiting on pharmacy".
Flomax 0.4 mg capsules revealed staff circled their initials on 1/1,5,6,7/18 without a notation as to why it was circled and not administered.

Review of the nurse's notes from 12/28/17 to 2/12/18 lacked any evidence the staff contacted the family or the medical provider to inform them the medication was not available and not administered as ordered.

During an interview on 2/13/18 at 4:08 PM certified staff #T reported if the medication is not in the cart to administer he/she would look thoroughly and if still could not find it he/she would call the pharmacy. Staff #T reported "most of the medications we get are on a monthly cycle so they should be in the facility somewhere." Staff #T reported he/she would find out who signed for it in the facility and call them to see if they might have put it someplace else.

During an interview on 2/13/18 at 4:10 PM facility nurse #F reported staff needed to call the pharmacy and then call the nurse and let the nurse know staff did not give the medication. Facility nurse #F stated the family provided the magnesium citrate and had not brought it in... stated the pharmacy did not carry that dose of magnesium citrate... stated he/she thought he/she had contacted the family multiple times regarding the magnesium not being available but could only find where he/she had contacted the family in November of 2017. Facility nurse #F reported the Trazodone probably was not given if

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the pharmacy was waiting for a prescription from the medical provider. Facility nurse #F did not have an explanation of why the Aricept and Flomax were not administered as ordered.

According to facility policy and procedure titled "Implementation of Medical Care Provider Orders" Process #7 - At least monthly during Resident review Home Supervisor will review all previously implemented orders to ensure compliance." The record lacked evidence of a review or corrective action in response to a review.

The Operator failed to ensure all medications and biologicals administered to #1013 in accordance with medical care provider's orders and in accordance with professional standards of practice.

- Review of record revealed #1011 admitted to facility 01/05/15 with diagnoses of dementia, depression, osteoarthritis, hypertension, fractured hip repair, and gastroesophageal reflux disease.

Current functional capacity screen dated 5/01/17 assessed #1011 unable to perform medication and treatment management.

Current negotiated service agreement/health service plan of 5/01/17 documented facility staff to provide medication and treatment management for #1011.

Comparison of the current February 2018 MAR (medication administration record) and current signed orders revealed a discrepancy.
MAR contained order: Depakote 125mg (milligrams) one tablet by mouth every evening at

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{S3200}	Continued From page 19 bedtime for mood stability. On 02/12/18, the most recent signed medical care provider order available in chart dated 4/04/17. This order directed Depakote 250mg one tablet by mouth at bedtime every day. On 02/12/18 at 5:30pm Operator #A confirmed current signed order not correct on the MAR for February 2018. On 02/13/18 at 8:30am Operator #A provided a physician's order sheet dated/signed 12/29/17. Operator #A stated this was at the medical care provider's office... I forgot yesterday we had these. Operator #A confirmed when February 2018 MAR's reviewed prior to use on 02/01/18, these pages at the medical care provider's office not used to ensure correct orders on current MAR. The Operator failed to ensure all medications and biologicals administered to #1011 in accordance with medical care provider's orders and in accordance with professional standards of practice.	{S3200}		
{S3216} SS=E	26-41-205 (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 facility 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:	{S3216}		

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{S3216}	Continued From page 20 (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 26-41-205 (i) The census equaled 26 current Residents and two discharged Residents. The sample included three Residents and one focused review. All Residents identified as receiving medication management. Based on interview and record review for one of three sampled (#1030) and one focused review (#1013) the Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications in sufficient detail for an accurate reconciliation according to acceptable standards of practice. Findings included: The roster and closed records identified all current and past Residents as receiving facility management of medications. - Review of Resident #1013 medical record revealed he/she admitted to the facility on 7/27/17	{S3216}		

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with diagnoses of organic affective disorder, constipation, anxiety and traumatic brain injury.

Review of the Functional Capacity Screen dated 12/6/17 revealed the resident could not manage his/her own medications.

Review of the Negotiated Service Agreement/Health service plan (NSA/HSP) dated 12/6/17 revealed facility staff would administer the Resident's medications. HSP also directed staff they could crush medications if not contraindicated.

Review of the physician's order sheets dated 10/2/17 identified the Resident received the following medications: Cymbalta (for depression), Linzess (for constipation), Klonopin (For aggression), Lithium Carbonate (for mood stability), Miralax (for constipation), Magnesium Citrate (supplement), Hydrocodone/acetaminophen (narcotic pain medication), Aricept (a memory medication), Oxybutynin (a bladder medication), Topamax (for lethargy), Clozaril (an antipsychotic medication), Flomax (for enlarged prostate), and Trazadone (an antidepressant).

Review of the Resident's medical record including nurse's notes lacked the names of the medications, the number of doses remaining at time of discharge or transfer, and where medications sent or if destroyed, record of destruction.

During an interview on 2/13/18 at 5:36 PM Operator #A reported the staff started keeping a notebook for deliveries and had a log for destroyed medications. Operator #A looked in multiple places and could not find record of the

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{S3216}	Continued From page 22 staff disposition of the Resident's medications. Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications in sufficient detail for an accurate reconciliation of #1013's medications according to acceptable standards of practice. - Record review revealed #1030 admitted to facility 7/29/17 with diagnoses of atrial fibrillation, congestive heart failure, edema, anemia, depression, gastroesophageal reflux disease, and hypertension. 7/29/17 functional capacity screen (FCS) completed by facility nurse #F assessed #1030 unable to perform medication and treatment management. 7/29/17 NSA completed by facility nurse #F documented facility staff to manage medications. 7/29/17 health care services plan (HSP) completed by facility nurse #F and Operator #A documented facility staff to administer medications, "takes meds whole may crush if needed and not contraindicated." Medications included in the December 2017 and January 2018 MAR (medication administration record) for #1030: Levothyroxine (thyroid replacement therapy), Linzess (for irritable bowel syndrome), Allopurinol (gout), Aripiprazole (depressive disorder), Atenolol (hypertension), Bumetadine (edema), Famotidine (ulcers), Fentanyl (narcotic pain control), Fluticasone (nasal steroid), Lorazepam (anti-anxiety), Nifedipine (hypertension and chest	{S3216}		

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pain), Oxybutynin (overactive bladder), Vitamin D3 (supplement), Ferrous sulfate (iron), Florinex (probiotic), Vitamin B12 (supplement), Brovana (bronchodilator), Cymbalta (anti depressant), Eliquis (anti coagulant), Atrovent (bronchodilator), Celluvisc (eye lubricant), Latanoprost (eye pressure), Lubrifresh (eye lubricant), Melatonin (sleep hormone), Mirtazipine (anti depressant), Albuteral (bronchodilator), Acetaminophen (pain and fever), Dulcolax (laxative), Colace (stool softener), Hydrocodone (narcotic pain control), Milk of magnesia (laxative), Natural tears (eye lubricant), Nystatin (anti fungal), Robitussin (cough), Senna (laxative), Simethicone (anti gas), Tessalon perles (cough), Diphenhydramine (allergy), and Loperimide (anti diarrheal).

Review of the Resident's medical record including nurse's notes lacked the names of the medications, the number of doses remaining at time of discharge or transfer, and where medications sent or if destroyed, record of destruction.

On 02/13/18 at 5:36pm Operator #A provided a recently implemented notebook that contained pharmacy delivery invoices. Operator #A looked in multiple locations of filing and record storage, and in medication rooms, but unable to locate any documentation for the disposition of #1030's medications... he she confirmed "I do not have documentation of what happened to #1030's medications."

On 02/15/18 facility nurse #F provided forms titled "Drugs returned or Destroyed" forms with barcode labels/Resident's name in patient name column. By Review this form contained barcode labels for Atenolol, Cymbalta, Aripiprazole,

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{S3216}	Continued From page 24 Allopurinol, Nifedipine, Levothyroxine, Vitamin D3, Oxybutynin, Vitamin B12, Eliquis, Cymbalta, Mirtazapine, Melatonin, Famotidine, and a partial label with partial barcode number and no medication name. The "date filled" column on one of the two pages contained "01/25/18" and an arrow drawn through the entire column, the second page remained blank. All other fields of these forms remained blank to include "Quantity Returned", "Quantity Destroyed", and "Reason for Return (please include dates if applicable)." The forms noted to have a pharmacy staff signature on each page, with a date of 01/30/18; a staff signature with no date on one of the two pages; a hand written note "from pharmacy" and a faxed date of 02/14/18. These records lacked the number of doses of each medication remaining and documentation of whether the medication was returned to the pharmacy for credit or destroyed. No documentation provided for the disposition of #1030's other medications which included controlled medications (Linzess, Bumetadine, Fentanyl, Fluticasone, Lorazepam, Ferrous sulfate, Florinex, Brovana, Atrovent, Celluvisc, Latanoprost, Lubrifresh, Albuteral, Acetaminophen, Dulcolax, Colace, Hydrocodone, Milk of magnesia, Natural tears, Nystatin, Robitussin, Senna, Simethicone, Tessalon perles, Diphenhydramine, and Loperimide. On 02/22/18 at 11:08am "Disposal of Medications" policy with a Revised date of 10/22/13 received. This policy includes in part: 4.. . ."The House pharmacy may have a policy that any unused bubble-packed medications and unopened tubes/bottles of medications supplied	{S3216}		

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{S3216}	Continued From page 25 by the House pharmacy may be returned with credit provided to the resident. 5. When a resident's medications are returned to the pharmacy, a Return to Pharmacy Record will be completed. Place these medications in the pharmacy pick-up box. 6. When a representative from the pharmacy arrives at the Residence to pick up the medications, he/she should sign the Return to Pharmacy record. He/She should also write the name of the pharmacy in the space. Give a copy of the Return to Pharmacy Record to the pharmacy representative if requested, with the Pharmacy Received and Returned envelope. 7. Controlled medications cannot be returned to the pharmacy. Thus, when these medications need to be destroyed, they must be placed in a medication disposal area for nurses to dispose of. a. Document the disposal on a Narcotic Inventory Sheet, with the date, time, amount and method of disposal noted. Both nurses witnessing must sign the Narcotic Inventory Sheet." Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications in sufficient detail for an accurate reconciliation of #1030's medications according to acceptable standards of practice.	{S3216}		
S3250 SS=D	26-41-105 (a) Resident Records a) The administrator or operator of each assisted living facility or residential health care facility 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	S3250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087083	A. BUILDING: _____ B. WING _____	R-C 02/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDER'S CREST, LLC	6887 E ROCKHILL STREET WICHITA, KS 67206

(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
S3250	Continued From page 26 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 26-41-105 (a) The census equaled 26 current Residents and two discharged Residents. The sample included three Residents and one focused review. Based on interview and record review for one focused review Resident (#1013) the Operator failed to ensure maintenance of Resident records in accordance with accepted professional standards and practices. Findings included: - Review of Resident #1013 medical record revealed he/she admitted to the facility on 7/27/17 with diagnoses of organic affective disorder, constipation, anxiety and traumatic brain injury. Review of the Functional Capacity Screen dated 12/6/17 revealed the Resident required physical assistance of staff with bathing, dressing, toileting, transfers and eating; unable to perform medication and treatment management. Review of the Negotiated Service Agreement/Health service plan (NSA/HSP) dated	S3250		

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S3250	Continued From page 27 12/6/17 revealed facility staff would provide moderate assistance of 1 staff for bathing, toileting, dressing, eating and grooming. Staff also to administer the Resident's medications. Review of the electronic record of nurse's notes revealed the following documentation inconsistencies: 1/4/18 at 10:59 PM - facility nurse #F documented - "1/4/18 - at approx. 1315 [1:15 pm] Resident was observed rubbing (his/her) shoulder and grabbing (his/her) back while readjusting self in chair. Due to a severe injury obtained nearly 7 years ago Resident has chronic pain. The nurse asked Resident if (he/she) was hurting to which (he/she) responded "yes, a lot" and rated pain an 8/10. A PRN (as needed) Norco was offered and Resident took willingly. At approx. 1430 [2:30 pm] the nurse followed up and Resident now states pain is under control and rates pain 2/10. Floor staff directed to contact nurse immediately if anymore agitation is observed." 1/4/18 at 10:59 PM - facility nurse #F documented - "1/4/18 At approx. 2200 [10:00pm] Resident presented with severe agitation and hallucinations. Resident is actively searching for spouse and stated he/she is not safe because people are coming to kill him/her. PRN Zyprexa given immediately. After 20 minutes Resident has had no effect and is still highly agitated. PRN Klonopin given per orders and at 2312 [11:23pm] Resident finally is resting comfortably in recliner and states he/she is no longer feeling "anxious". Resident displayed no signs or symptoms of agitation up until 2200 [10:00 p.m.] and behavior started suddenly. No other concerns at this time. Floor staff directed to contact nurse immediately if anymore agitation is observed."	S3250		

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S3250	Continued From page 28 This entry dated 1/4/18 and time stamped at 10:59 PM recorded that at 2312 (11:12 PM) the Resident rested comfortably. This documented information occurred 13 minutes after the time stamp of facility nurse #F's notation in the Resident's record. On 1/6/18 at 2:59 PM - "1/4/18 at approx. 1315 [1:15 pm] Resident was observed rubbing (his/her) shoulder and grabbing (his/her) back while readjusting self in chair. Due to a severe injury obtained nearly 7 years ago Resident has chronic pain. The nurse asked Resident if (he/she) was hurting to which (he/she) responded "yes, a lot" and rated pain an 8/10. A PRN Norco was offered and Resident took willingly. At approx. 1430 [2:30pm] the nurse followed up and Resident now states pain is under control and rates pain 2/10. Floor staff directed to contact nurse immediately if anymore agitation is observed." This entry is a duplicate of the entry date and time stamped 1/4/18 at 10:59 p.m. On 1/6/18 at 2:59 PM -"1/4/18 At approx. 2200 resident presented with severe agitation and hallucinations. Resident is actively searching for spouse and stated he/she is not safe because people are coming to kill him/her. PRN Zyprexa given immediately. After 20 minutes Resident has had no effect and is still highly agitated. PRN Klonopin given per orders and at 2312 Resident finally is resting comfortably in recliner and states he/she is no longer feeling "anxious". Resident displayed no signs or symptoms of agitation up until 2200 and behavior started suddenly. No other concerns at this time. Floor staff directed to	S3250		

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S3250	Continued From page 29	S3250		

contact nurse immediately if anymore agitation is observed."

This entry is a duplicate of the entry date and time stamped 1/4/18 at 10:59 p.m.

Facility nurse #F's written statement to address how the computer system worked documented "when entering charting electronically you only have 90 seconds to enter the information. If you go over 90 seconds the program will cut out and charting is lost. Because of this I often type charting in word then cut the text and copy it into the Cerner (type of electronic charting) for charting. ... Instead of attempting to delete the repeated documentation, I add the correct/current documentation to that day and date /time my entry of the event."

During an interview on 2/13/18 at 2:08 PM facility nurse #F reported that he/she used a word document to chart and then would copy and paste it into the electronic medical record. #F stated he/she would lose documentation after 90 seconds when inputting it into the electronic record. To demonstrate facility nurse #F typed in a record "several seconds" and stopped typing. The surveyor asked him/her to continue to type and he/she said that as long as he/she typed it would save. If he/she left the computer it would close out after 90 seconds and would lose it all. Using timer on licensed nurse F's phone, noted the electronic documentation record closed after 3 minutes when no keystrikes entered. When licensed nurse #F went back to retrieve the note, it was gone. #F stated he/she got called away from the desk a lot so that is why he/she used a word document to copy and paste... stated the

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S3250	Continued From page 30 duplicate documentation was probably because he/she did not properly click on the note to copy it and so the computer just put in the last note she copied. Review of the undated facility policy titled "Electronic and Paper Charting" provided to KDADS on 11/10/17 during another visit to facility, lacked any process or specifications to address these described practices. The Operator failed to ensure maintenance of #1013's record in accordance with accepted professional standards and practices.	S3250		