STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	R 02/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJORIE'S HOME LLC	14601 TIMBER LAKE ROAD WICHITA, KS 67230

(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
{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit of the above home plus facility on 2/5/18, 2/6/18, 2/12/18, and 2/13/18.	{S 000}		
{S5028} SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)(A)(C)(F)	{S5028}		

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

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{S5028}	Continued From page 1 The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 2 (#1050 and #1070) of 3 residents sampled, operator/owner/licensed nurse B failed to report to the department within 24 hours allegations of potential abuse and/or neglect, failed to thoroughly investigate the allegations and failed to maintain a written record of each investigation. Findings included: - Record review for resident #1050 revealed an admission date of 10/30/15 with diagnoses of dementia, arthritis, anxiety, and depression. Functional capacity screen dated 9/25/17 indicated resident required physical assistance with toileting, transferring, and mobility in wheelchair; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement/health care service plan dated 9/25/17 documented services of physical assistance with toileting and mobility, two-person assistance with transferring, and interventions to address resident's risk for falls as routine night checks and body alarm. Nurse's care notes contained the following entries: 12/20/17 by operator/owner/licensed nurse B that he/she received a call from staff at 8:00 p.m. on 12/19/17 to report resident was in recliner in living room, alarm sounded, and resident slid out of recliner to the floor. Operator/owner/licensed nurse B documented he/she reviewed the video	{S5028}		

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{S5028}	Continued From page 2	{S5028}		

recording of the incident and reported to the department.

12/28/17 by licensed nurse C that on 12/27/17 staff notified him/her at approximately 6:45 p.m. resident's alarm sounded and staff found resident on floor by his/her chair in living room. Licensed nurse C documented he/she viewed the video and observed resident stood up from chair, tripped, and fell.

1/15/18 by operator/owner/licensed nurse B documented staff notified him/her around 10:00 p.m. on 1/13/18 that resident rolled out of bed and staff found resident on the floor. Operator/owner/licensed nurse B documented resident's "alarm was on but it was on (resident) off the bed."

During an interview at 10:55 a.m. on 2/6/18, operator/owner/licensed nurse B explained his/her documentation of the alarm on resident at time of incident 1/13/18 that the tab alarm was attached to resident's clothing but was not attached to bed linens and prevented alarm from sounding when resident rolled out of bed. Operator/owner/licensed nurse B stated he/she investigated each incident by watching the video of the incident and conducted a verbal interview with staff person on duty
Operator/owner/licensed nurse B stated he/she did not complete a written investigation of each of the 3 incidents and did not report the incidents on 12/27/17 and 1/13/18 to the department.

Operator/owner/licensed nurse B failed to report to the department within 24 hours allegations of potential abuse and/or neglect of resident #1050, failed to thoroughly investigate the allegations, and failed to maintain a written record of each

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{S5028}	Continued From page 3 investigation,. - Record review for resident #1070 revealed an admission date of 10/15/16 with diagnoses of Alzheimer's disease, anxiety, and depression. Functional capacity screen dated 10/2/17 indicated resident was independent with transferring; required supervision with walking; experienced impaired short-term memory, long-term memory, memory recall, and decision making; exhibited wandering behavior; and was at risk for falls. Negotiated service agreement/health care service plan dated 10/5/17 documented resident independent with transferring and ambulating and staff to perform routine night check and body alarm at night. Record contained an amended negotiated service agreement dated 11/29/17 that documented "If resident (not) sleeping at night/notify nurse on call (and) wake second staff for assistance to help. If resident wandering unsafe during day, notify nurse." Nurse's care notes contained the following entries: 12/18/17 operator/owner/licensed nurse B documented at 11:00 a.m. that staff called him/her to report resident's body alarm sounded and staff found resident sitting on floor by bathroom door. 1/29/18 licensed nurse C documented he/she received phone call from staff at 6:30 a.m. to report resident entered another resident's room, sat on that resident's bed, and slid off bed. Staff found resident trying to get up. (Note: entry did not document a witness to the incident.)	{S5028}		

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{S5028}	Continued From page 4 During an interview at 11:15 a.m. on 2/6/18, operator/owner/licensed nurse B stated the nurse's care notes entry on 12/18/17 was an incident that occurred in the resident's room at 10:00 p.m. on 12/15/17. Operator/owner/licensed nurse B could not provide the time staff had last visualized resident and resident's activity. Operator/owner/licensed nurse B stated the incident on 1/29/18 occurred after a staff member got resident up and dressed for the day and left resident to ambulate on own. Resident entered another resident's room and fell. Operator/owner/licensed nurse B stated one staff member was viewed on video camera but did not know location and activity of the second staff member. Operator/owner/licensed nurse B stated he/she did not report the incidents to the department and did not investigate either incident. Operator/owner/licensed nurse B failed to report to the department within 24 hours allegations of potential abuse and/or neglect of resident #1070, failed to thoroughly investigate the allegations and failed to maintain a written record of each investigation,.	{S5028}		
{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.	{S5155}		

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{S5155}	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review, interview, and observation for 3 (#1070, #1060, and #1050)of 3 residents sampled, operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #1070 revealed an admission date of 10/5/16 with diagnoses of Alzheimer's disease, depression, and anxiety. Functional capacity screen dated 10/2/17 indicated resident was independent with transferring, required supervision with walking; and was unable to bathe, dress, toilet, feed self, and manage medications and treatments; was occasionally incontinent of urine; experienced impaired short-term memory, long-term memory, memory recall, and decision making; was at risk for falls; and exhibited wandering behavior. Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/5/17 documented physical assistance with bathing, dressing, toileting, personal hygiene, eating a regular diet, and administration of medications and treatments. NSA/HCSP documented staff to	{S5155}		

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{S5155}	Continued From page 6	{S5155}		

perform routine night checks and use of a body alarm at night. Record contained an amended NSA dated 11/28/17 that documented resident to receive regular liquids "swallow OK." Amended NSA dated 11/29/17 documented staff to notify on-call nurse if resident not sleeping at night and wake second staff person for assistance and if resident wandering unsafe during day, notify nurse.

Nurse's care notes contained the following entries:

12/5/17at 4:00 p.m. licensed nurse C documented meeting with medical care provider, hospice and family member related to resident's falls and pacing. Order received for Xanax (antianxiety medication) for restlessness and agitation. Staff to toilet resident, offer drink, snack, and notify nurse. Resident's weight 89 pounds continue to offer scheduled dietary supplement and snacks.

12/18/17 operator/owner/licensed nurse B documented at 11:00 a.m. that staff called him/her to report resident's body alarm sounded and staff found resident sitting on floor by bathroom door. This entry lacked documentation of when staff last toileted resident or resident's activity prior to fall.

1/29/18 licensed nurse C documented he/she received phone call from staff at 6:30 a.m. to report resident entered another resident's room, sat on that resident's bed, and slid off bed. Staff found resident trying to get up. This entry did not specify if the staff person woke the second staff person to supervise resident's activity.

12/15/17 licensed nurse C documented resident

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{S5155}	Continued From page 7	{S5155}		

with a stage 2 pressure ulcer (loss of upper layer of skin) on coccyx/left buttock. Wound cleansed and Calmoseptine (ointment to heal skin irritation) applied. Hospice notified to check on getting resident a different mattress and gel cushion.

The NSA/HCSP lacked revision to address resident's skin breakdown including interventions to heal and promote further skin breakdown. The licensed nurse placed an "X" beside preventive skin care on the HCSP but did not list out interventions.

Record contained a medical care provider's order dated 1/23/18 to change resident's diet to mechanical soft. NSA/HCSP lacked the service of a mechanical soft diet.

During an interview at 3:06 p.m. on 2/5/18, operator/owner/licensed nurse B stated resident was at risk for falls due to resident's wandering behavior. Operator/owner/licensed nurse B confirmed he/she did not evaluate if current interventions related to resident's risk for falls were effective after resident experienced falls. Operator/owner/licensed nurse B stated resident was at risk for skin breakdown due to incontinence and staff needed to toilet resident more often. Operator/owner/licensed nurse B stated the NSA/HCSP lacked the service of a mechanical soft diet.

During an interview at 11:15 a.m. on 2/6/18, operator/owner/licensed nurse B stated he/she did not follow up to ensure hospice provided a mattress and gel cushion to resident. Licensed nurse C went to resident's room, returned and stated resident had a different mattress and staff used a facility owned gel cushion for resident.

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{S5155}	Continued From page 8 Operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1070 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #1060 revealed an admission date of 12/6/16 with diagnoses of Parkinson's disease, coronary artery disease, and hypertension. Functional capacity screen dated 11/28/17 indicated resident required physical assistance with toileting, transferring, dressing, and eating; was unable to perform bathing, and management of medications and treatments; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/28/17 documented service of use of a Hoyer (mechanical lift with a sling to support resident during transfer) lift as needed for transferring resident, side rails for positioning only, staff to check on resident every hour when resident in bed, and use of a body alarm. The NSA lacked a description of transfer assistance required by resident. Resident's record lacked documentation of a licensed nurse assessment of the safety of the side rail device and resident's ability to safely use the side rails for positioning. Record contained a medical care provider's order dated 1/30/18 to discontinue use of a sit-to-stand lift due to resident's inability to use safely and may use Hoyer lift or two-person transfer assistance.	{S5155}		

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{S5155}	Continued From page 9 During an interview at 3:30 p.m. on 2/5/18, operator/owner/licensed nurse B stated resident required two staff members to transfer resident with or without the Hoyer lift. At 10:23 a.m. on 2/6/18, surveyor went to resident #1060's room and observed a Hoyer lift and a hospital bed with 1/2 side rail up on each side of bed. At 10:30 a.m. on 2/6/18, operator/owner/licensed nurse B stated resident used the side rails to assist when he/she was repositioned. Operator/owner/licensed nurse B stated he/she had assessed the safety of the side rails and resident's ability to safely use side rails but did not document an assessment in the resident's record. Operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1060 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #1050 revealed an admission date of 10/30/15 with diagnoses of dementia, arthritis, anxiety, and depression. Functional capacity screen dated 9/25/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility in wheelchair, and eating; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement/health care service	{S5155}		

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{S5155}	Continued From page 10	{S5155}		

plan dated 9/25/17 documented services of routine night check and body alarm.

Nurse's care notes contained the following entries:

12/20/17 by operator/owner/licensed nurse B that he/she received a call from staff at 8:00 p.m. on 12/19/17 to report resident was in recliner in living room, alarm sounded, and resident slid out of recliner to the floor.

12/28/17 by licensed nurse C that on 12/27/17 staff notified him/her at approximately 6:45 p.m. resident's alarm sounded and staff found resident on floor by his/her chair in living room. Licensed nurse C documented he/she viewed the video and observed resident stood up from chair, tripped, and fell.

1/15/18 by operator/owner/licensed nurse B documented staff notified him/her around 10:00 p.m. on 1/13/18 that resident rolled out of bed and staff found resident on the floor. Operator/owner/licensed nurse B documented resident's "alarm was on but it was on (resident) off the bed."

During an interview at 10:55 a.m. on 2/6/18, operator/owner/licensed nurse B explained his/her documentation of the alarm on resident at time of incident 1/13/18 that the tab alarm was attached to resident's clothing but was not attached to bed linens and prevented alarm from sounding when resident rolled out of bed.

NSA/HCSP lacked revision after these incidents to include interventions to address resident's risk for falls.

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{S5155}	Continued From page 11 During an interview at 10:43 a.m. on 2/6/18, operator/owner/licensed nurse B stated routine night check and body alarm were the only interventions in the NSA to address resident's risk for fall. Operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1050 and were in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
{S5300} SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home 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 home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR26-42-205(d)	{S5300}		

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{S5300}	Continued From page 12 The facility reported a census of 8 residents. The sample included 2 residents. Based on record review and interview for 2 (#1070 and #1050) of 3 residents sampled, the operator/owner/licensed nurse B failed to ensure medications were administered to each resident in accordance with professional standards of practice. Findings included: - Record review for resident #1070 revealed an admission date of 10/5/16 with diagnoses of Alzheimer's disease, depression, and anxiety. Functional capacity screen dated 10/2/17 indicated resident was unable to manage medications; experienced impaired short-term memory, long-term memory, memory recall, and decision making; was at risk for falls; and exhibited wandering behavior. Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/5/17 documented physical assistance with administration of medications and when wandering staff to toilet resident or offer a snack. Record contained an amended NSA dated 11/29/17 that documented staff to notify on-call nurse if resident not sleeping at night and wake second staff person for assistance and if resident wandering unsafe during day, notify nurse. Nurse's care notes contained an entry dated 12/5/17at 4:00 p.m. by licensed nurse C of a meeting with medical care provider, hospice and family member related to resident's falls and pacing. Order received for Xanax (antianxiety medication) for restlessness and agitation. Staff to toilet resident, offer drink, snack, and notify nurse.	{S5300}		

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{S5300}	Continued From page 13 Review of the 12/5/17 through 12/31/17 medication administration record (MAR) revealed resident received Xanax 1 milligram by mouth every 4 hours as needed for diagnoses of anxiety, restlessness, agitation. The MAR contained documentation certified staff administered one dose of this medication to resident on December 4, 5, 6, 7, 8, 9, 10, 12, 15, 19, 20, 23, 29, 30, and 31, 2017 and 2 doses on December 3, 13, 14, and 25, 2017. The MAR contained documentation by certified staff that medication was administered for increased anxiety, increased restlessness, and agitation and then documented results of "effective." The MAR or the resident's record lacked documentation of an assessment by a licensed nurse to determine that other interventions were not effective to reduce resident's anxiety, agitation, restlessness and that the antianxiety medication was indicated. Review of the 1/1/18 through 1/31/18 MAR revealed resident received one dose of Xanax 1 milligram by mouth as needed for anxiety, agitation, restlessness on January 1, 2, 4, 6, 7, 8, 9, 10, 11, 15, 17, 18, 21, 22, 29, and 31, 2018 and 2 doses on January 3, 5, 12, 14, 16, 19, and 2018. The MAR contained documentation by certified staff that medication was administered for increased anxiety or increased restlessness and then documented results of "slightly effective" or "effective." The MAR or the resident's record lacked documentation of an assessment by a licensed nurse to determine that other interventions were not effective to reduce resident's anxiety, agitation, restlessness and that the antianxiety medication was indicated. Review of the 2/1/18 through 2/5/18 MAR reveled certified staff administered one dose of Xanax 1	{S5300}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	R 02/13/2018

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{S5300}	Continued From page 14	{S5300}		

milligram by mouth as needed for anxiety, agitation, and restlessness on 2/1/18 and 2/2/18. The MAR or the resident's record lacked documentation of an assessment by a licensed nurse to determine that other interventions were not effective to reduce resident's anxiety, agitation, restlessness and that the antianxiety medication was indicated.

At 2:37 p.m. on 2/5/18, when asked for documentation of a licensed nurse assessment of the resident prior to administration of Xanax, operator/owner/licensed nurse B stated certified staff made phone call to the nurse for approval to give the medication. Operator/owner/licensed nurse B stated the licensed nurse did not document an assessment of resident's need for the medication.

The 12/5/17 through 12/31/17 MAR contained an entry beginning 12/21/17 for resident to receive Robinol (for excessive oral secretions) 1 milligram by mouth 1 or 2 tablets three times a day at 9:00 a.m., 1:00 p.m., and 9:00 p.m. The 1/1/18 through 1/31/18 MAR documented the same dose and frequency of the medication until an order change on 1/26/18 to Robinol 1 milligram 1 or 2 tablets by mouth two times a day at 9:00 a.m. and 3:00 p.m. The MARs lacked documentation by certified staff if 1 or 2 tablets administered at each administration time. The MARs lacked documentation by a licensed nurse to determine if resident required one tablet or 2 tablets.

During an interview at 2:09 p.m. on 2/5/18, operator/owner/licensed nurse B stated he/she told certified staff to always give 2 tablets of Robinol for each dose. Operator/owner/licensed nurse B confirmed the MAR did not indicate

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{S5300}	Continued From page 15 certified staff administered 2 tablets. Operator/owner/licensed nurse B failed to ensure medications were administered to resident #1070 in accordance with professional standards of practice. - Record review for resident #1050 revealed an admission date of 10/30/15 with diagnoses of dementia, arthritis, anxiety, and depression. Functional capacity screen dated 9/25/17 indicated resident was unable to perform medication; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement/health care service plan dated 9/25/17 documented certified staff administered medications to the resident and staff to sit with resident when resident agitated. Review of the 1/1/18 through 1/31/18 and the 2/1/18 through 2/5/18 medication administration records (MARs) revealed an entry for Xanax (antianxiety medication) 0.5 milligram take 1 tablet by mouth every 4 hours as needed for anxiety. The MARs contained documentation that certified staff administered 1 dose of the medication to resident on January 6, 8, 12, 19, 23, 27, 28, and 29, 2018 and on 2/4/18 and 2/5/18 and 2 doses on January 11, 15, and 18, 2018. Certified staff documented medication given to resident for increased anxiety and medication effective. The MARs or the record lacked documentation of a licensed nurse assessment to determine that other interventions were not effective to reduce resident's anxiety and that the antianxiety medication was indicated.	{S5300}		

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{S5300}	Continued From page 16 At 11:0 a.m. on 2/6/18, operator/owner/licensed nurse B stated certified staff called the nurse prior to administering Xanax but nurse did not document an assessment of resident's need for the medication. Operator/owner/licensed nurse B failed to ensure medications were administered to resident #1050 in accordance with professional standards of practice.	{S5300}		