STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B088002	A. BUILDING: _____ B. WING _____	R 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ESTATES HOME PLUS	1140 S PERSHING AVENUE LIBERAL, KS 67901

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 18-3 of the above home plus facility on 2/7/18, 2/8/18, and 2/12/18.	{S 000}		
{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 4 residents and 1 adult day care resident. The sample included 3 residents. Based on record review and interview for 3 (#1023, #1021, and #1022) of 3 residents sampled, the operator failed to ensure the 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 #1023 on 2/7/18 revealed an admission date of 7/2/17 with diagnoses of congestive heart failure, type 2 diabetes mellitus, atrial fibrillation, and	{S5155}		

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

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{S5155}	Continued From page 1	{S5155}		

hypertension.

Functional capacity screen (FCS) dated 1/29/18 indicated resident was independent with walking with walker; required supervision with dressing, toileting, and transferring; physical assistance with bathing; unable to perform management of medications and medical treatments; was not cognitively impaired; and was at risk for falls. Licensed nurse C documented in the ordered therapies and treatments section that resident required "Weekly PT/INR using home testing kit." [A blood test used to help monitor the effectiveness of the anticoagulant medication warfarin prescribed for resident due to diagnosis of atrial fibrillation. INR stands for international normalized ratio that is calculated from the prothrombin time (PT).]

Negotiated service agreement/health care service plan (NSA/HCSP) dated 2/5/18 documented facility staff assisted resident with toileting, transferring, and bathing and licensed nurse and staff monitored vital signs, administered medications, and performed a weekly INR test.

During an interview at 5:07 p.m. on 2/7/18, licensed nurse C stated he/she performed the weekly PT/INR testing for the resident and reported value to resident's medical care provider. Licensed nurse C confirmed the NSA/HCSP lacked the identity of the person performing the testing.

Resident record contained documentation by licensed nurse C at 11:45 a.m. on 1/2/18 that resident fell when he/she leaned forward while sitting on a walker. Licensed nurse C documented resident was trying to pick up a sock from the floor and brakes were not locked on

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{S5155}	Continued From page 2 walker causing walker to slide out from under resident. NSA/HCSP lacked interventions to address resident's risk for falls. During an interview at 10:15 a.m. on 2/8/18, operator B confirmed the NSA/HCSP lacked interventions to address the resident's risk for falls until added today. Medical care provider's written orders dated 7/26/17 included daily weight, administer metolazone (diuretic given for fluid retention in congestive heart failure) 2.5 milligrams as needed for weight gain of 3 pounds of more, and notify medical care provider of weight gain or loss of 5 pounds or more. Review of the daily weight records from 12/27/17 through 2/8/18 revealed no weight recorded on December 27, 28, 29, 30, and 31, 2017; January 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 15, 16, 17, and 28, 2018. The vital sign flow sheet contained documentation of resident's weight: 1/05/18 165 pounds at doctor's office 1/12/18 171.4 pounds 1/13/18 170.4 pounds 1/14/18 168 pounds 1/19/18 167.3 pounds 1/20/18 167.1 pounds 1/21/18 174 pounds "reported by resident"	{S5155}		

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{S5155}	Continued From page 3 1/22/18 165.4 pounds and rechecked by staff 175.8 1/23/18 173.2 pounds 1/24/18 165.8 pounds 1/25/18 169.1 pounds at 8:00 a.m. and 172.2 pounds at 1:30 p.m. 1/26/18 172 pounds 1/27/18 171.2 pounds 1/29/18 174 pounds 1/30/18 168.2 pounds 1/31/18 171.6 pounds with shoes on 2/01/18 169.6 pounds 2/02/18 162.2 pounds 2/03/18 161.8 pounds 2/04/18 176.2 pounds with shoes on 2/05/18 174.8 pounds 2/06/18 172.8 pounds 2/7/18 170.2 pounds NSA/HCSP lacked monitoring of daily weight and person responsible to obtain and record resident's weight. Record contained documentation by licensed nurse C sent to resident's medical care provider	{S5155}		

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{S5155}	Continued From page 4 on 2/5/18 that resident's weight varied from 161 pounds to 176.2 pounds with resident to receive metolazone 2.5 milligrams if resident gained 3 or more pounds in a day. Licensed nurse C documented he/she was not sure what was causing weight fluctuations but he/she was not comfortable giving resident the medication for weight gain. Medical care provider responded in writing on 2/6/18 with order to only give metolazone if resident was symptomatic with shortness of breath and edema of lower extremities. During an interview at 10:15 a.m. on 2/8/18 licensed nurse C stated he/she had not assessed the resident on 2/6/18, 2/17/18, or 2/8/18 for shortness of breath and edema of lower extremities. Licensed nurse C confirmed certified staff did not obtain resident's weight on a daily basis and this service was not specified in the resident's NSA/HCSP. Record contained a medical care provider's order for finger stick blood sugar monitoring 3 times a day. The medication administration record notebook contained instruction to obtain resident's blood sugar every day before breakfast and lunch and at bedtime. Blood sugar log lacked documented blood sugar results at bedtime on 1/1/18; before lunch on January 7, 8, 11, 14, 17, and 28, 2018. NSA/HCSP lacked the service of blood sugar monitoring and the persons responsible to obtain the value. During an interview at 10:15 a.m. on 2/8/18, operator B confirmed the NSA/HCSP lacked the service of blood sugar testing and the persons responsible to perform the test.	{S5155}		

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{S5155}	Continued From page 5 Operator B failed to ensure licensed nurse C provided or coordinated the provision of necessary health care services that met the needs of resident #1023 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #1021 revealed an admission date of 1/6/17 with diagnoses of congestive heart failure, chronic respiratory failure, and type 2 diabetes mellitus. Functional capacity screen dated 1/4/18 indicated resident was unable to perform management of medications and medical treatments. Negotiated service agreement/health care service plan (NSA/HCSP) dated 1/6/18 documented staff to monitor resident's oxygen saturation, weight, and blood sugar level daily and administer medications. NSA/HCSP documented resident required supplemental oxygen using an oxygen concentrator. A note attached to the medication administration record notebook documented instruction to staff to obtain resident's weight, blood pressure, oxygen saturation, and blood sugar before breakfast. Review of the vital sign flow sheet from 12/27/17 through 2/8/18 revealed no documentation of resident's oxygen saturation on January 4, 5, 8, 11, and 15, 2018 and on 2/2/18. The vital sign flow sheet lacked documentation of a daily weight on January 3, 4, 5, 6, 7, 8, 10, 11, 13, 15, 16, and 22, 2018 and on 2/4/18. Resident's weight on 2/7/18 recorded as 178.9 pounds and on 2/8/18 recorded as 182.6 pounds (a 3.7 pound weight	{S5155}		

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{S5155}	Continued From page 6	{S5155}		

gain in one day). Resident's medication administration record documented resident to receive metolazone (diuretic given for fluid retention in congestive heart failure) 5 milligrams by mouth as needed for weight gain of 3 or more pounds. The medication administration record did not indicate resident received this medication.

At 9:10 a.m. on 2/8/18, certified staff D stated he/she weighed resident yesterday morning before breakfast and this morning after breakfast as his/her explanation for resident's weight increase and resident did not need to take metolazone medication. Certified staff D stated resident was to be weighed before breakfast but that some days he/she forgot to weigh resident.

During an interview on 2/8/18, licensed nurse C confirmed staff did not weigh resident before breakfast every day and did not record oxygen saturation every day.

Operator B failed to ensure licensed nurse C provided or coordinated the provision of necessary health care services that met the needs of resident #1021 and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #1022 revealed an admission date of 5/4/17 with diagnoses of stroke and dementia.

Functional capacity screen dated 4/19/17 indicated resident required physical assistance with bathing, dressing, toileting, and walking; supervision with transferring; experienced impaired short term memory, long term memory, memory recall, and decision making; was at risk for falls; and was blind.

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{S5155}	Continued From page 7 Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/27/17 documented staff to assist with bathing, toileting, transferring, and walking. NSA/HCSP did not address resident's risk for falls. Nurse's notes contained an entry by licensed nurse C on 1/10/18 that staff found resident sitting on floor. Resident had a bruise to back of head and shoulder area. Operator B provided his/her documentation of the incident that was not part of the resident's record. Operator B documented resident was sitting on couch in lounge area at 9:10 p.m. on 1/10/18. Certified staff was in kitchen area, turned around and saw resident standing up from couch. Resident was unsteady and fell before certified staff could reach resident. Operator B documented fall interventions of frequent checking of resident when asleep, close observation when awake, and offer resident food when fidgety. During an interview at 10:15 a.m. on 2/8/18, operator B confirmed resident's NSA/HCSP lacked interventions to address resident's risk for falls until added 2/7/18. Operator B failed to ensure licensed nurse C provided or coordinated the provision of necessary health care services that met the needs of resident #1022 and were in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
{S5251} SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents	{S5251}		

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{S5251}	Continued From page 8 (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 4 residents and 1 adult day care resident. The sample included 3 residents. Based on record review and interview for 1 (#1022) of 3 residents sampled, the licensed nurse failed to ensure the resident's record contained complete documentation of an incident that included time of the incident, action taken, and results of the action. Findings included: - Record review for resident #1022 revealed an admission date of 5/4/17 with diagnoses of stroke and dementia. Functional capacity screen dated 4/19/17 indicated resident required physical assistance with bathing, dressing, toileting, and walking; supervision with transferring; experienced impaired short term memory, long term memory, memory recall, and decision making; was at risk for falls; and was blind. Negotiated service agreement/health care service plan (NSA/HCSP) dated 4/27/17 documented staff to assist with bathing, toileting, transferring, and walking. NSA/HCSP did not address resident's risk for falls.	{S5251}		

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{S5251}	Continued From page 9 Nurse's notes contained the following entries: On 1/10/18, licensed nurse C documented he/she was notified by staff that they found resident sitting on floor. Resident had a bruise to back of head and shoulder area. Licensed nurse C did not document the time of the fall and did not document the time he/she made the entry in the resident's record. Licensed nurse C documented vital signs were taken but did not document the actual vital signs of resident. Licensed nurse C documented "Ice applied" but did not document where the ice was applied. The entry lacked a complete nursing assessment. Licensed nurse C documented he/she notified resident's medical care provider of the incident by fax and called and left message for resident's family member to return the nurse's call. On 1/12/18 licensed nurse C documented resident's family member returned nurse's call and nurse informed family member of resident's fall. Licensed nurse documented "1/10/18 L.E." "Neuro intact. ROM as usual." (Note L.E. abbreviation used for late entry. Neuro abbreviation for neurological. ROM abbreviation for range of motion.) Record lacked documentation of a follow up assessment of the resident by the nurse. Operator B provided his/her documentation of the incident that was not part of the resident's record. Operator B documented resident was sitting on couch in lounge area at 9:10 p.m. on 1/10/18. Certified staff was in kitchen area, turned around and saw resident standing up from couch.	{S5251}		

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{S5251}	Continued From page 10 Resident was unsteady and fell before certified staff could reach resident. At 2:48 p.m. on 2/7/18, licensed nurse C stated he/she did not document the time he/she made the entry in the resident's record, did not document the time of the incident, location of the incident, or resident's vital signs. Licensed nurse C stated he/she applied ice to the resident's shoulder. Licensed nurse C stated he/she instructed certified staff to take resident's vital signs during the night but did not document this. Licensed nurse C stated he/she assessed the resident on 1/11/18 but did not document the assessment. Licensed nurse C failed to ensure resident #1022's record contained complete documentation of an incident that included time of the incident, action taken, and results of the action.	{S5251}		