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 12/28/2017

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, Correction Order visit #17-26, Notice of Assessment visit #17-27, Ban on Admission visit #17-22 at the above named Residential Health Care Facility in Wichita, Kansas on 12/14/17, 12/19/17, 12/20/17, 12/21/17, 12/27/17, and 12/28/17.	{S 000}		
{S3155} SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility 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 26-41-204 (a) The census equalled 28 the sample included three Residents and one focused review completed. Based on interviews and reviews of records, for one of three sampled (#13), 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 screen (FCS) and the negotiated service agreement (NSA). Findings included:	{S3155}		

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{S3155}	Continued From page 1 - Review of record revealed #13 admitted to facility 6/23/17 with diagnoses of major depressive disorder, organic affective disorder, and history of traumatic brain injury. The previous 6/23/17 functional capacity screen (FCS) and the current 12/06/17 FCS each assessed #13 in need of physical assistance with bathing, dressing, toileting, transfers, and eating; in need of supervision with mobility; unable to perform medication and treatment management; with occasional bladder incontinence; with falls/unsteadiness, impaired vision and hearing; with wandering, socially inappropriate behaviors, and impaired decision making. The 6/23/17 FCS assessed #13 with short term and long term memory, decision making and memory recall impairments. The 12/06/17 FCS assessed #13 with no long term memory impairment. The 6/23/17 FCS assessed #13 as sometimes understandable and usually understands; the 12/06/17 FCS assessed #13 as usually understood and usually understands. The 6/23/17 health service plan (HSP) section titled "Mental Attitude" identified #13 with "elopement risk, pleasant/cooperative at times, socially interactive, worries, follows instruction at times, sundowning, depressed, agitated easily at times." The intervention or note recorded: "can be agitated at times - helps to talk to about grandkids or children to redirect - one on one time" The 6/23/17 HSP section titled "Behaviors" identified #13 with "wandering". The intervention or note recorded: "Wants to go home - may exit seek - monitor when goes	{S3155}		

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{S3155}	Continued From page 2	{S3155}		

outdoors" (this HSP included a hand written note added 12/09/17 after the new HSP developed on 12/06/17 - "every 15 minute check - escort to bathroom")

The record contained a new NSA/HSP dated 12/06/17.

The 12/06/17 HSP section titled "Mental Attitude" identified #13 with "elopement risk, pleasant/cooperative, socially interactive, worries, follows instruction, repetitive questions or comments, sundowning, depressed, agitated easily, public sexual behavior"
The intervention or notes recorded: "when Resident is trying to elope, follow Resident and begin a conversation in order to distract. When Resident wants to walk outside in courtyard must be accompanied to prevent elopement. 12/09/17 hand written note added Res on 15 minute check supervised when wants out of facility or commons area... when not pleasant and cooperative distract with conversation, walking, talking... likes to assist staff with tasks... inform task has been completed (when worrying about)... assure spouse will be back soon... walk and talk with #13 when displaying sundowning in the evening... reassure of love when depression evident... redirect agitation with conversation... remove self from area if sexual suggestions voiced"

Facility nurses notes (NN) included:

11/14/17 - 4:04pm - seen by medical provider due to painful urination
Next entry - 12/09/17 at 2:59pm - spoke with Resident's spouse at approximately 1432 and alerted of incident earlier today - spouse apologized for Resident's behavior and I assured there was no need to apologize we were able to

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{S3155}	Continued From page 3	{S3155}		

correct the situation right away - did advise spouse of abrasions to knees but no other injury noted at this time - souse to be in town on Monday as Resident has doctor appointments

12/09/17 - 4:12pm - at 0950 staff report that Resident went to use the bathroom and after he/she was finished stated wanted to lay down for awhile, at 1020 2 staff members were in another room assisting another Resident when they looked out the window and seen this Resident walking in the parking lot, both staff immediately went out and guided Resident back into the building, this writer out to assess, Resident has abrasion areas to bilateral knees with no bleeding noted, no further injuries noted, VSS (vitals), Resident had removed the screen window out of bedroom, crawled out of it, and crawled over the fence to the parking lot, when speaking to Resident states wants to go home, gave PRN (as needed) Zyprexa to calm Resident down, placed call to physician and spouse... placed on 15 minute visual checks for intervention at this time

By observation on 12/14/17 at 3:43pm in Resident's room, #13 laying on bed fully clothed, with shoes on, alone in room. #13 opened eyes and quietly greeted.
Observation of window (facing North) revealed a small white plastic box on upper window frame, and when attempted to lift the window an alarm sounded.

On 12/14/17 at 3:43pm Operator #A stated we installed that alarm today... crawled over fence (after crawling through window) into the from parking lot area... walked around the East side of the building, heading South when staff observed from another Resident room on the back South/East corner of building.

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{S3155}	Continued From page 4 Observation of outside area revealed a courtyard outside of #13's window with a board fence approximately six feet tall surrounding the area. North of this fence a sidewalk and parking area, with circle drive (left) that led to main city streets, and (to right) led to an undeveloped field and another parking area behind the building. By interview on 12/14/17 at 4:00pm, Operator #A and facility nurse #F stated the interventions added to the HSP due to elopement included 15 minute checks. By confidential interviews, multiple certified employees stated #13 consistently voiced desire to leave facility... stating I gotta get out of here, etc. By interviews, no reported instances of #13 leaving prior to 12/09/17. By interview on 12/19/17 at 5:18pm, facility nurse #F stated I was only on half days at time of admission... wasn't present when #13 came into building... didn't assess or care for until the next day (admission HSP signed/dated by facility nurse #F 6/23/17)... familiar with #13 from other houses although I didn't do direct care... aware of elopement risk and that #13 had eloped before but not when or where... I know we put in that particular room so if #13 went out the window would be in an enclosed courtyard... current plan is to have someone's eyes on him/her at all times when not in the commons area of unit... also came to facility with a bed alarm on bed... I don't know about window thing for sure but that's why we put him/her in that room... plan at admission was stand by assist because not steady on feet... more recently was steady on feet and had stopped exit seeking...	{S3155}		

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{S3155}	Continued From page 5 On 12/27/17 at 4:22pm, facility nurse #F confirmed no elopement assessment completed on #13 at time of admission to facility or since admission. For #13, the Operator failed to ensure the licensed nurse provided or coordinately the necessary health care services to meet the Resident's needs.	{S3155}		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The census equalled 28 the sample included three Residents and one focused review completed. Based on interviews and reviews of records, for three of three sampled (#13, #12, and #11) and for one focused review (#15), the Operator failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan (HSP). Findings included: - Review of record revealed #13 admitted to facility 6/23/17 with diagnoses of major depressive disorder, organic affective disorder,	S3165		

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and history of traumatic brain injury.

The previous 6/23/17 functional capacity screen (FCS) and the current 12/06/17 FCS each assessed #13 in need of physical assistance with bathing, dressing, toileting, transfers, and eating; in need of supervision with mobility; unable to perform medication and treatment management; with occasional bladder incontinence; with falls/unsteadiness, impaired vision and hearing; with wandering, socially inappropriate behaviors, and impaired decision making. The 6/23/17 FCS assessed #13 with short term and long term memory, decision making and memory recall impairments. The 12/06/17 FCS assessed #13 with no long term memory impairment. The 6/23/17 FCS assessed #13 as sometimes understandable and usually understands; the 12/06/17 FCS assessed #13 as usually understood and usually understands.

The current 12/06/17 negotiated service agreement (NSA) and health care service plan (HSP) documented #13 to receive services to address needs identified on the FCS.
The NSA and HSP contained the statement "All care will be overseen by the Director of Resident Care, Home Supervisor/Nurse and other designated or contracted staff of facility."
The NSA and HSP lacked the name of the nurse responsible for the implementation and supervision of the HSP.

- Review of record revealed #12 admitted to facility 10/16/17 with diagnoses of major neurocognitive disorder.

The previous 10/16/17 functional capacity screen (FCS) and the current 12/06/17 FCS each

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assessed #12 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; unable to perform medication and treatment management; with bladder incontinence; with impaired long term and short term memory, memory recall, and decision making; usually understood and usually understands for communication; with falls/unsteadiness and impaired decision making.

The 10/16/17 FCS assessed #12 in need of supervision with eating, the 12/06/17 FCS assessed in need of physical assistance with eating. The 10/16/17 FCS recorded no wheel chair used, the 12/06/17 recorded wheelchair used.

The current 12/06/17 negotiated service agreement (NSA) and health care service plan (HSP) documented #12 to receive services to address needs identified on the FCS.
The NSA and HSP contained the statement "All care will be overseen by the Director of Resident Care, Home Supervisor/Nurse and other designated or contracted staff of facility."
The NSA and HSP lacked the name of the nurse responsible for the implementation and supervision of the HSP.

- Review of record revealed #11 admitted to facility 7/08/16 with diagnoses not specified.

The current 5/01/17 functional capacity screen (FCS) assessed #11 in need of physical assistance with bathing, dressing, toileting, transfers; unable to perform mobility, medication and treatment management; incontinent of bladder; with short term and long term memory, memory recall, and decision making impairments;

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sometimes understandable and usually understands for communication; with falls/unsteadiness, disruptive behaviors, impaired decision making; used a mechanical lift and a wheelchair.

The current 5/01/17 negotiated service agreement (NSA) and health care service plan (HSP) documented #11 to receive services to address needs identified on the FCS.
The NSA and HSP contained the statement "All care will be overseen by the Director of Resident Care, Home Supervisor/Nurse and other designated or contracted staff of facility."
The NSA and HSP lacked the name of the nurse responsible for the implementation and supervision of the HSP.

- Review of record revealed #15 admitted 01/18/17 with no diagnoses specified on face sheet.

The functional capacity screen of 02/20/17 identified physical assistance needed with bathing, dressing, toileting, transfers, mobility; in need of supervision with eating, unable to perform medication and treatment management; with memory and cognition impairments, usually understood and usually understands communication; with falls/unsteadiness, impaired vision and hearing, wandering, and impaired decision making.

The current 02/20/17 negotiated service agreement (NSA) and health care service plan (HSP) documented #15 to receive services to address needs identified on the FCS.
The NSA and HSP contained the statement "All care will be overseen by the Director of Resident

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S3165	Continued From page 9 Care, Home Supervisor/Nurse and other designated or contracted staff of facility." The NSA and HSP lacked the name of the nurse responsible for the implementation and supervision of the HSP. The Operator failed to ensure the NSA's for #13, #12, #11, and #15, contained the name of the licensed nurse responsible for the implementation and supervision of the HSP.	S3165		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The census equalled 28 the sample included three Residents, and one focused review completed. The facility identified all Residents as receiving health care services. Based on interviews and reviews of record, for one of three sampled with monthly lab orders (#13), for one of three sampled with orders for suction (#12), and for one of three sampled with order for twice daily tooth brushing (#13), the Operator failed to ensure all health care services provided to Residents by qualified staff in accordance with acceptable standards of practice. Findings included:	S3171		

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S3171	Continued From page 10 - Review of record revealed #13 admitted to facility 6/23/17 with diagnoses of major depressive disorder, organic affective disorder, and history of traumatic brain injury. The current functional capacity screen of 12/06/17 assessed #13 in need of physical assistance with all activities of daily living (ADL) except mobility, with impaired short term memory, memory recall and decision making; with fall/unsteadiness, wandering, behaviors, and impaired decision making. The current negotiated service agreement (NSA) and health service plan (HSP) of 12/06/17 recorded services for identified needs to be provided by facility staff. By review, the medical record contained physician orders for: "CBC (complete blood count lab) monthly due on 7/12/17, order dated 6/23/17 "Assure Resident brushes teeth in AM and HS (bedtime), order dated 4/19/17 The medical record lacked monthly CBC lab results. The record contained one lab result dated 9/22/17. The December 2017 MAR (medication administration record) lacked initials to document staff assured tooth brushing completed by Resident or assisted by staff. On 12/14/17 at 2:00pm facility nurse #F stated no labs in the chart because "I only do labs when the psych nurse requests it."	S3171		

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S3171	Continued From page 11 On 12/14/17 at 2:26pm facility nurse #F stated "I guess when home health took over they were to get labs... so I am going to check with them to see if they have them." The record lacked a home health care plan. After review of the original order at admission, facility nurse #F contacted the medical care provider, the lab, and the home health service for #13 to initiate a monthly lab testing as ordered. #F provided a letter that stated there had been an oversight in regards to who was responsible to do the lab. On 12/20/17 at 6:45pm facility nurse #F and business office manager #J confirmed initials for tooth brushing not on the MAR... the area for twice daily initials remained blank... stated that task may be on the care kiosk... confirmed no licensed nurse monitoring this task/order to see that it was being done and why not documented. The Operator failed to ensure qualified staff provided all health care services to #13 as ordered and in accordance with acceptable standards of practice. - Review of record revealed #12 admitted to facility 10/16/17 with diagnoses of major neurocognitive disorder. The current 12/06/17 FCS assessed #12 in need of physical assistance with all activities of daily living (ADL), with impaired long term and short term memory, memory recall and decision making; with fall/unsteadiness, impaired decision making, and used wheelchair.	S3171		

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S3171	Continued From page 12 The current negotiated service agreement (NSA) and health service plan (HSP) of 12/06/17 recorded services for identified needs to be provided by facility staff. By review, the medical record contained physician orders for: "May use oral suction for thick secretions if patient is unable to clear them" order dated 12/14/17 On 12/14/17 at 10:30am observed hospice staff on phone in front lobby discussing new orders with family member to include discontinue Haldol, begin Ativan, and suction as needed. This conversation in regard to visit just completed on #12. By review of record after family conversation, the order for oral suction placed on the MAR (medication administration record). The fax phone order from APRN (advanced practice registered nurse) placed in the chart and a note placed on the care kiosk for documentation of hospice visits to facility. On 12/14/17 at 3:43pm Operator #A stated "we do not do suctioning in this facility... I will have to get a copy of the admission agreement... not sure that it includes statement that facility does not do suctioning." On 12/20/17 at 2:41pm facility nurse #F stated hospice nurse #O talked with family and he/she hadn't told me... "I thought about that, that #12 might need to be suctioned... but hospice nurse #O said upon assessing and listening to #12, didn't think he/she needed to be... gave	S3171		

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S3171	Continued From page 13 Robitussin and it helped so the order for suction was discontinued." On 12/20/17 the medical record contained an additional order also dated 12/14/17. This order identical in regard to discontinued Haldol and started Ativan, but did not include the order for suctioning. The MAR suction order had a note added "hospice only" and now with a diagonal line through the order, and the word "error" next to it. The medical record lacked an assessment by qualified licensed staff of #12 to demonstrate the signs or symptoms that prompted the order for suctioning. The medical record lacked the re-assessment and discussion by qualified licensed staff that led to the discontinuation of the orders placed earlier. The Operator failed to ensure qualified staff provided all health care services to #12 as ordered and in accordance with acceptable standards of practice.	S3171		
{S3200} SS=F	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:	{S3200}		

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{S3200}	Continued From page 14 (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)(1-2) The census equalled 28 the sample included three Residents and one focused review completed. Based on interviews and reviews of records, for three of three sampled (#13, #12, and #11), the Operator failed to ensure all medications and biologicals administered in accordance with a medical provider's written orders and in accordance with professional standards of practice. Findings included: - Review of record revealed #11 admitted to facility 7/08/16 with no diagnoses specified. The current functional capacity screen (FCS) of 5/01/17 assessed #11 unable to perform medication and treatment management. The current negotiated service agreement (NSA) of 5/01/17 documented facility staff to provide medication management. Comparison of the December 2017 MAR (medication administration record) with current signed medical provider orders revealed	{S3200}		

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{S3200}	Continued From page 15 discrepancies: The December 2017 MAR contained an order for Divalproex Sodium DR (anti seizure) 125mg (milligrams) one tablet by mouth every evening at bed time for mood stability. The POS (physician order sheet)/recapitulation of orders signed by APRN #B on 10/02/17 included two orders for Divalproex - one for 125mg daily and one for 250mg daily. The record lacked documentation of any attempt to clarify the accuracy of the signed orders. By review the POS contained duplicate orders with different origination dates for Aricept (Alzheimer's), Aspirin (cardiac protection), Wellbutrin (antidepressant), Celebrex (anti inflammatory), and Lasix (diuretic), and the record lacked documentation of any attempts to clarify accuracy. The Operator failed to ensure all medications and biologicals administered to #11 in accordance with written orders and in accordance with professional standards of practice. - Review of record revealed #12 admitted to facility 10/16/17 with diagnosis of major neurocognitive disorder. The current functional capacity screen (FCS) of 12/06/17 and the prior FCS of 10/16/17 assessed #12 unable to perform medication and treatment management. The current negotiated service agreement and health service plan of 12/06/17 recorded medication/treatment management by facility staff.	{S3200}		

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{S3200}	Continued From page 16 Comparison of the December 2017 MAR (medication administration record) with current signed medical care provider orders revealed discrepancies: December 2017 MAR contained an order dated 12/06/17 for Scopolamine Transdermal patch to be applied every three days. The medical record lacked a signed order for this medication. A fax order provided from Home Health on 12/14/17 included a nurse signature but lacked a physician signature. According to initialed administration spaces, the medication not initiated until 12/11/17. Review of available doses of Scopolamine patches, and ordered/delivered doses failed to reconcile. The administration record and the nurses' notes lacked any documentation or explanation for the delay in initiating the medication order, lacked any documentation of the Resident's response to the new medication, and lacked documentation of discrepancy in number of remaining doses available. December 2017 MAR contained an order dated 12/01/17 for Guaituss syrup take 10ml (milliliters) by mouth three times a day for five days (then use script for as needed dose). According to initialed administration spaces, Guaituss administered three times daily for eight days instead of five. The medical record and the administration record lacked documentation or explanation for the failure to follow the written order. On 12/14/17, December 2017 MAR contained administration of PRN (as needed) doses of Ativan (anti anxiety) at 0800 on 12/12/17 and a dose at 11:41 on 12/12/17. These administrations lacked legible times medication given, the route,	{S3200}		

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{S3200}	Continued From page 17	{S3200}		

an assessment of the need for the medication and the Resident's response to the medication. On 12/20/17, this December 2017 MAR contained added documentation of the PRN doses of Ativan - to include the route (tablet, oral, topical) and the Resident's response to the medication ("effective").

On 12/20/17 at 1:33pm facility nurse #F and business office manager #J confirmed medications administered on the the December 2017 MAR failed to match written orders in accordance with professional standards of practice.

The Operator failed to ensure all medications and biologicals administered to #12 in accordance with written orders and in accordance with professional standards of practice.

- Review of record revealed #13 admitted to facility 6/23/17 with diagnoses of major depressive disorder, organic affective disorder, and history of traumatic brain injury.

The previous 6/23/17 functional capacity screen (FCS) and the current 12/06/17 FCS each assessed #13 unable to perform medication and treatment management.

The current 12/06/17 negotiated service agreement (NSA) and health care service plan (HSP) documented #13 to receive medication management by facility staff.

By review a 12/09/17 nurses' note described #13's elopement from facility on 12/09/17. The nurses' note documented upon return to facility Resident received a PRN (as needed) dose of

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{S3200}	Continued From page 18 Zyprexa (anti depressant/anti psychotic)"to calm Resident down." The December MAR (medication administration record) lacked documentation of any Zyprexa administered to #13, on 12/09/17 or any other date in December. On 12/20/17 at 7:30pm facility nurse #F and business office manager #J confirmed nurses' note recorded Zyprexa given but no Zyprexa dose documented on MAR with time, dosage, route, and response, in accordance with professional standards of practice. By review, the December 2017 MAR recorded two doses of Clonazepam (seizure, panic attacks, short term anxiety) administered on 12/13/17. In the PRN record, both doses administered at different times of the day (0800 and 1700) recorded on the same line with a single "reason" or indication as "having behaviors." The record lacked description of the "behaviors", assessments of Resident, and lacked interventions or alternatives attempted and the outcome or results of those attempted interventions. The results/response column contained "effective" as the one word documentation for two different doses at two different times of day. This practice not in accordance with professional standards of practice. On 12/20/17 at 5:56pm facility nurse #F and business office manager #J confirmed documentation not in accordance with standards of practice to include documentation of PRN doses with the symptoms medication meant to treat, an assessment of Resident's need for the medication, documentation of alternatives attempted, and the results of the medication	{S3200}		

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{S3200}	Continued From page 19 given. Comparison of the December 2017 MAR with written physician orders revealed discrepancies: MAR contained an order for Magnesium Citrate 200mg (milligrams) take one tablet by mouth every day. This order recorded an origination date of 6/23/17. The medical record contained a faxed physician order dated 6/24/17 "Change dose of Magnesium Citrate to 170mg two po (by mouth) noon." By review the newer 6/24/17 order never recorded on the MAR or on the most recent listing of Physician Order Sheet (POS) dated 10/02/17. The order on the POS determined transcribed incorrectly as it recorded the directions from the order of 6/23/17, but dated as new order of 6/24/17. The medical record and the nurses' notes lacked evidence of attempt to clarify the correct dosage for this Resident in accordance with professional standards of practice. The record documented #13 never received 170mg two tablets as ordered 6/24/17. On 12/20/17 at 5:56pm facility nurse #F and business office manager #J confirmed the POS of 10/02/17 did not match the order recorded and signed on 6/24/17... facility nurse #F stated that is why we quit the electronic MAR so they can't push things on or change without our knowing... The Operator failed to ensure all medications and biologicals administered to #13 in accordance with written orders and in accordance with professional standards of practice.	{S3200}		

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{S3216}	Continued From page 20	{S3216}		
{S3216} SS=D	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: (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 equalled 28 the sample included three Residents and one focused review completed. The Resident roster identified all Residents as receiving medication management. Based on observation, interviews and reviews of records, for one of three sampled (#12) the Licensed nurses and Medication aides failed to maintain records of receipt and disposition of	{S3216}		

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{S3216}	Continued From page 21	{S3216}		

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 record revealed #12 admitted to facility 10/16/17 with diagnosis of major neurocognitive disorder.

The current functional capacity screen (FCS) of 12/06/17 and the prior FCS of 10/16/17 assessed #12 unable to perform medication and treatment management.
The current negotiated service agreement and health service plan of 12/06/17 recorded medication/treatment management by facility staff.

By review the 12/2017 paper MAR (medication administration record) recorded an order with an origination date of 12/06/17 for: "Transdermal Scopolamine 1.5 mg/3 day Place behind ear and change every 3 days for excess secretions." The paper MAR with a line drawn across the page at the administration time of 8:00pm from 12/01/17 to 12/11/17.
The MAR documented the first dose administered at 8:00pm on 12/11/17, a second dose administered on 12/14/17...
The MAR and the medical record nurses notes lacked documentation of why the new order implementation delayed from 12/06/17 to 12/11/17.

By review the 12/2017 electronic MAR recorded

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{S3216}	Continued From page 22 an order with an origination date of 12/11/17 for: "Transderm Scopolamine 1.5mg/3 day Place behind ear and change every 3 days for excess secretions." The electronic MAR contained empty boxes highlighted for initials beginning on 12/11/17 every three days. The electronic MAR lacked any documentation of administered doses and lacked any documentation of the reason doses not administered. By review the medical record lacked a physician's order for the Transdermal scopolamine. The medical record contained a fax from the home health dated 12/14/17. This fax contained an order dated 12/06/17 "Scopolamine patch 1.5% place behind ear and change every 3 days for excess secretions." This fax order contained the signature of a hospice nurse but lacked the signature of a physician. On 12/20/17 at 1:33pm facility nurse stated the medication got approved on 12/06/17... it got ordered... the order went to pharmacy... for whatever reason it did not correlate with what the medication aides were seeing on the electronic MAR... Operator #A and business office manager #J decided we would go to paper MAR's on the 11th... all the time I've been in this field have never been asked about acquisition and disposition of non-controlled medications... confirmed no system in place to accurately account for acquisition and disposition of non-controlled medications. Facility nurse #F provided copy of signed delivery receipt from pharmacy dated 12/06/17. This record documented the arrival of four Scopolamine patches at facility on 12/06/17 at	{S3216}		

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{S3216}	Continued From page 23 14:59 (2:59pm). Certified medication aide #L signed the delivery confirmation. Facility nurse #F provided the plastic baggie which contained the Scopolamine patches. This baggie with a prescription label dated 12/12/17 "4 patches" sent contained two patches. Facility nurse #F stated this delivery ordered because the first ones ordered on 12/06/17 never arrived... (this explanation in spite of the certified medication aide signature on 12/06/17 delivery receipt and initials on the MAR medication administered 12/11/17. With two deliveries of four patches each and three doses administered per dates on MAR, there should have been five patches remaining instead of two. On 12/20/17 at 4:00pm facility nurse presented a new delivery baggie of Scopolamine patches that just arrived at facility. The label on the package documented 12/12/17 "4 patches." On 12/20/17 at 4:17pm Surveyor phoned pharmacy and spoke with the dispensing pharmacist #M... he/she stated facility nurse #F called earlier and stated they didn't get meds on 12/06/17... in order to not charge Resident again, I had to date the same as the last delivery... our inventory shows all twelve patches sent and delivered to the facility 12/06/17, 12/12/17, and today 12/20/17... we have a signed delivery receipt and that matches or inventory... On 12/20/17 at 4:40pm facility nurse stated maybe there were no patches in the first delivery... On 12/20/17 at 4:45pm certified staff #L stated I never called pharmacy today... I did call them on 12/12/17 to ask for more patches... #L confirmed he/she documented administration of patch on	{S3216}		

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{S3216}	Continued From page 24 12/11/17... Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications for #12 and for all Residents in sufficient detail for an accurate reconciliation.	{S3216}		
{S3261} SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f) The census equalled 28 the sample included three Residents and one focused review completed. Based on interviews and reviews of records, for two of three sampled (#13 and #12) and for one focused review (#15), the Operator failed to ensure the Resident's record contained 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. Findings included: - Review of record revealed #13 admitted to facility 6/23/17 with diagnoses of major depressive disorder, organic affective disorder, and history of traumatic brain injury.	{S3261}		

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{S3261}	Continued From page 25 The current functional capacity screen of 12/06/17 assessed #13 in need of physical assistance with all activities of daily living (ADL) except mobility, with impaired short term memory, memory recall and decision making; with fall/unsteadiness, wandering, behaviors, and impaired decision making. The current negotiated service agreement (NSA) and health service plan (HSP) of 12/06/17 recorded services for all ADLs. Although #13 admitted 6/23/17, the first nurses notes (NN) entry of the medical record began on 7/26/17. The record lacked any documentation of #13's admission and arrival at facility. The record lacked any assessment of #13's physical and mental status at time of admission, and any provided acclimation or orientation to facility and Resident's comprehension of these. On 12/14/17 at 3:50pm facility nurse #F stated maybe no nurses notes because they were logged in under another house when making notes from 6/23/17 to 7/26/17. Facility nurse later provided nurses notes from #13's prior placement, but these notes ended with his/her discharge on 6/23/17 to this facility. By review of medical care provider visits to facility on 11/14/17, 10/10/17, 9/26/17, and 6/27/17, dictated notes referenced agitation, behaviors, combativeness, history of exit seeking and attempts to elope. The NN of medical record lacked a description of these dictated signs and symptoms, and the NN lacked actions taken or Resident's response to the actions taken. By confidential interviews of multiple employees,	{S3261}		

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reported that from time of admission to present #13 consistently verbalized desire/intent to "leave" and "get out of here" and that #13 struck #15 on the morning of 12/19/17.

On 12/19/17 at 5:20pm, the medical record NN lacked documentation of agitation, combativeness, Resident's verbalized intent or desire to leave, and lacked documentation of #13 striking #15 on 12/19/17.

On 12/20/17 at 3:10pm facility nurse #F and business office manager #J confirmed a Resident #13 to Resident #12 abuse occurred on 12/19/17 and provided a typed word document from the office. This document not part of the medical record and lacked a date and time.

On 12/20/17 at 7:00pm the medical record NN lacked documentation of the Resident to Resident altercation, assessment of #13, actions taken in response to the incident, and Resident's response to the actions taken.

By review on 12/20/17 at 7:00pm, the medical record NN of #15 lacked documentation of the Resident to Resident altercation, assessment of #15 for injuries, actions taken in response to the incident, and #15's response to the actions taken.

On 12/20/17 at 7:30pm facility nurse #F and business office manager #J confirmed the record lacked documentation.

The Operator failed to ensure #13's record and #15's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the

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{S3261}	Continued From page 27 action. - Review of record revealed #12 admitted to facility 10/16/17 with diagnoses of major neurocognitive disorder. The current 12/06/17 FCS assessed #12 in need of physical assistance with all activities of daily living (ADL), with impaired long term and short term memory, memory recall and decision making; with fall/unsteadiness, impaired decision making, and used wheelchair. The current 12/06/17 negotiated service agreement (NSA) and health care service plan (HSP) recorded services to address all needs identified on the FCS. By review, the admission diet order for #12 recorded as "Regular", and Regular diet included on the 10/16/17 NSA. The NSA/HSP of 12/06/17 documented mechanical soft diet. The medical record lacked a physician's order to change the diet. The medical record lacked documentation of why or when this diet order changed. The Nurses Notes (NN) recorded: 11/14/17 - 3:29pm - "Resident seen by APRN (advanced practice registered nurse) today - orders received to schedule 0.5mg (milligrams) by mouth Haldol at supper for agitation/psychosis - Resident presents with increased agitation at suppertime and becomes combative - increase ferrous sulfate to twice daily for anemia and have staff observe for constipation." The medical record lacked documentation of	{S3261}		

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	N087083	A. BUILDING: _____ B. WING _____	R 12/28/2017

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{S3261}	Continued From page 28	{S3261}		

episodes of agitation/psychosis, the signs and symptoms, the interventions attempted to address agitation/psychosis and the results of the interventions attempted.

12/01/17 - 10:59pm - "Resident presented today with thick mucous that he/she was spitting out of mouth and wheezing present bilateral in lungs. This nurse contacted the PCP (primary care physician) and DPOA (durable power of attorney) and order were obtained and approved to obtain a chest X-ray. Start Robitussin TID (three times daily) x 5 days and Robitussin 10ml (milliliters) every 4 hours PRN Chest X-ray results were negative and showed no pneumonia present at this time. Floor staff will continue to observe and report any changes to nurse on duty or nurse on call. Resident is still eating/drinking and tolerating well. No orders for a diet change currently."

This documentation lacked the time of day #12 presented with symptoms of mucous and wheezing, time of day and location of X-rays. This documentation lacked time and who assisted #12 with excess mucous and his/her response to the assistance.
The record lacked any follow up assessment of Resident or Resident's response to the interventions.

The next entry in NN dated 12/04/17 at 10:59pm - "Resident is not showing any improvement while utilizing PT/OT (physical therapy/occupational therapy services. Resident also still displays signs of terminal restlessness. After discussion with the PCP and DPOA the decision was made to refer him/her to Hospice. A home health visit was made today so Hospice will evaluate for appropriateness tomorrow."

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{S3261}	Continued From page 29 The record lacked documentation of an assessment of Resident to demonstrate a lack of improvement with therapy. Review of Home Health visit note dated 12/02/17 recorded: "Patient has made improvements with therapy. Patient still requires assistance with all transfers and gait, but is able to perform with less physical assistance from staff." 12/06/17 - 10:59pm - "Home Health found Resident to be appropriate for Hospice and is admitted onto services as of today." 12/07/17 - 10:59pm - "LE (late entry) - 12/06/17 at 1500. Hospice obtained orders for Scopolamine patch due to excess secretions. Order if for 1mg patch to be changed every 72 hours. And oxygen PRN at 2 liters via nasal cannula per Hospice protocol. Right now Resident's oxygen is good at 96% on room air. Blood pressure 138/68 pulse 72 respirations 16 temperature 98.2" The record lacked documentation of an assessment of #12's presentation of excess secretions, who assisted #12, what interventions attempted, and the results of attempted interventions. On 12/20/17 at 1:33pm facility nurse #F and business office manager #J confirmed the nurses notes lacked these items... facility nurse #F stated I didn't realize we had to write a nurse's note every time a Resident took a medication... The Operator failed to ensure #12's record contained 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.	{S3261}		

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S3290 SS=E	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(b)(2) The census equalled 28 the sample included three Residents and one focused review completed. The facility identified all Residents with meal service. Based on interviews and	S3290		

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reviews of records, for two of three sampled (#13 and #12), the Operator failed to ensure a medical care provider's order on file in the record when a Resident's negotiated service agreement (NSA) included a therapeutic diet, mechanically altered diet, or thickened consistency.

Findings included:

- Review of record revealed #13 admitted to facility 6/23/17 with diagnoses of major depressive disorder, organic affective disorder, and history of traumatic brain injury.

The current functional capacity screen of 12/06/17 assessed #13 in need of physical assistance with bathing, dressing, toileting, transfers, and eating; with impaired short term memory, memory recall and decision making; with fall/unsteadiness, wandering, behaviors, and impaired decision making.

The current NSA and health service plan (HSP) of 12/06/17 recorded Resident to receive a Mechanical soft diet.
The previous NSA and HSP of 6/23/17 recorded Resident to receive a Mechanical soft diet.

The medical record lacked a physician's order for a mechanical soft diet.

- Review of record revealed #12 admitted to facility 10/16/17 with diagnoses of major neurocognitive disorder.

The current 12/06/17 FCS assessed #12 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, eating; with impaired long term and short term memory, memory recall

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S3290	Continued From page 32 and decision making; with fall/unsteadiness, impaired decision making, and used wheelchair. The current NSA and health service plan (HSP) of 12/06/17 recorded Resident to receive a mechanical soft diet. The admission diet order for #12 recorded as "Regular", and Regular diet included on the 10/16/17 NSA. The medical record lacked a physician's order for a mechanical soft diet. On 12/20/17 at 2:41pm facility nurse #F stated "don't have to have an order to downgrade a diet... never have..." At this time facility nurse #F was sending text to medical care provider... #F stated he/she was "just trying to get a copy of the order from medical care provider for diet change." The Operator failed to ensure a physician's order for mechanical soft diet in the record for #12 and #13 when the NSA was changed from Regular diet to Mechanical Soft.	S3290		