STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087067	A. BUILDING: _____ B. WING _____	11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVITA SENIOR LIVING AT ROLLING HILLS	629 S MAIZE COURT WICHITA, KS 67209

(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 the resurvey at the above named facility on 11-8-17, 11-9-17, 11-14-17, 11-15-17, 11-16-17, 11-27-17, 11-28-17, 11-29-17 and 11-30-17.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(2) The facility identified a census of 90 residents. The sample included 6 residents. Based on record review, interview and observation for 1 (#300) of 6 residents sampled, designated facility staff failed to conduct a Functional Capacity Screen (FCS) following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #300 on 11-14-17 at 11:00 a.m. revealed an admit date of 6-8-17 with diagnoses of depressive disorder, osteoarthritis, osteoporosis, and insomnia.	S3081		

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

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S3081	Continued From page 1	S3081		

The admission FCS dated 6-9-17 recorded resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, no falls/unsteadiness, impaired decision making, or inappropriate behaviors. Resident experienced bladder incontinence, decision making and long term memory loss.

The nurse progress notes recorded resident involved in resident to resident altercations on 6-23-17, 6-25-17, 6-26-17, 8-31-17, 10-9-17, and 10-16-17.

The nurse progress notes recorded resident was yelling/cursing/at residents and staff on the following dates: 6-14-17, 7-21-17, 8-21-17, 8-31-17, 10-1-17, 10-9-17, 10-12-17, 10-14-17, 10-23-17, and 11-2-17.

11-2-17 at 5:18 a.m. Resident has been a two person assist with transfers and activities of daily living. Resident cursing/yelling at other residents and staff.

11-12-17 at 2:53 p.m. Resident requiring two person heavy assist for transfers, unable to stand on lower extremities and is exceeding care needed for this facility.

Interview on 11-14-17 at 11:35 a.m. with licensed nurse A stated he/she should have done a significant change FCS as resident did have a significant change in condition with impaired cognition, combative with staff and residents, exhibited inappropriate behaviors, required two staff assist with activities of daily living, and required a two person transfer.

On 11-14-17 at 1:00 p.m. observed three plus pitting edema to both bi-lateral lower extremities.

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S3081	Continued From page 2 Interview on 11-14-17 at 1:05 p.m. with certified staff J and K stated resident is a two person transfer and unable to assist with transfer. Resident is confused, combative, and yells/screams at staff and other residents. Prior to resident becoming dependent on staff for transfer resident used to wander into other resident rooms. Certified staff J and K transferred resident from wheelchair to toilet using gait belt. Resident was dependent on both staff for transfer and did not assist with transfer. For resident #300, designated facility staff failed to conduct a FCS following any significant change in condition as defined in K.A.R. 26-39-100.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by:	S3092		

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S3092	Continued From page 3 KAR 26-41-202(d) The facility identified a census of 90 residents. The sample included 6 residents. Based on record review, interview and observation for 1 (#300) of 6 residents sampled, the administrator failed to ensure the review of the Negotiated Service Agreement (NSA) following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #300 on 11-14-17 at 11:00 a.m. revealed an admit date of 6-8-17 with diagnoses of depressive disorder, osteoarthritis, osteoporosis, and insomnia. The admission FCS dated 6-9-17 recorded resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, no falls/unsteadiness, impaired decision making, or inappropriate behaviors. Resident experienced bladder incontinence, decision making and long term memory loss. The admission NSA dated 6-5-17 recorded resident is independent with activities of daily living and may require reminders/cues for bathing/incontinence. The NSA/Health Care Plan (HCP) dated 6-8-17 recorded resident independent with dressing, bathing, eating, transfers, has a walker and wheelchair. Wheelchair used for long distances. Resident at risk for fall related to confusion. Staff to monitor for changes in resident and communicate with the physician. The nurse progress notes recorded resident had	S3092		

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resident to resident altercations on 6-23-17, 6-25-17, 6-26-17, 8-31-17, 10-9-17, and 10-16-17.

The nurse progress notes recorded resident was yelling/cursing/at residents and staff on the following dates: 6-14-17, 7-21-17, 8-21-17, 8-31-17, 10-1-17, 10-9-17, 10-12-17, 10-14-17, 10-23-17, and 11-2-17.

11-2-17 at 5:18 a.m. Resident has been a two person assist with transfers and activities of daily living. Resident cursing/yelling at other residents and staff.

11-12-17 at 2:53 p.m. Resident requiring two person heavy assist for transfers, unable to stand on lower extremities and is exceeding care needed for this facility.

Interview on 11-14-17 at 11:35 a.m. with licensed nurse A stated he/she should have done a significant change NSA as resident did have a significant change in condition with impaired cognition, combative with staff and residents, exhibited inappropriate behaviors, required two staff assist with activities of daily living, and required a two person transfer.

On 11-14-17 at 1:00 p.m. observed three plus pitting edema to both bi-lateral lower extremities.

Interview on 11-14-17 at 1:05 p.m. with certified staff J and K stated resident is a two person transfer and unable to assist with transfer. Resident is confused, combative, and yells/screams at staff and other residents. Prior to resident becoming dependent on staff for transfer resident used to wander into other resident rooms. Certified staff J and K

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S3092	Continued From page 5 transferred resident from wheelchair to toilet using gait belt. Resident was dependent on both staff for transfer and did not assist with transfer. For resident #300, the administrator failed to ensure the review of the NSA following any significant change in condition as defined in K.A.R. 26-39-100.	S3092		
S3155 SS=G	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 facility identified a census of 90 residents. The sample included 6 residents. Based on record reviews, interviews, and observations for 3 (#111, #100, #500) of 6 residents sampled, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) that meet the needs of cognitive impaired residents who experienced falls/unsteadiness. Findings included:	S3155		

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S3155	Continued From page 6 - Record review for resident #111 revealed an admit date of 7-30-13 with diagnoses of dementia, anxiety, osteoarthritis, and edema. The annual FCS dated 7-18-16 recorded resident required supervision for toileting, transfer, walking/mobility, and eating, physical assistance with bathing, dressing, bladder incontinence, experienced short term memory loss, memory recall, long term memory loss, decision making and falls/unsteadiness. The annual and revised NSA/HCS dated 9-9-16 recorded resident required one person physical assist for bathing, physical assist with toileting, physical assist with mobility and remind to use walker for stability when ambulating, provide physical assist to and from meals and activities. Resident required assistance with moods/behaviors: Provide behavior intervention one to three times daily-redirect when pacing, seems agitated, use the photo books from family. Resident required one person assist for dressing and physical assist to safety in an emergency. Resident uses a front wheeled walker and the doctor "okayed" resident to ambulate without walker if chooses to, remind resident go slow pace when using walker. The significant change FCS dated 11-15-16 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence experienced short term memory loss memory recall, long term memory loss, decision making, impaired decision making, and falls/unsteadiness. The significant change NSA dated 11-17-16 recorded resident required assistance with	S3155		

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bathing, dressing, toileting, mobility to and from meals and activities to ensure use of walker, and assist with transfers. Redirect/re-approach resident for behaviors, agitation, care refusal and restlessness.

The NSA/HCS dated 11-17-16 and the annual NSA/HCS dated 7-31-17 recorded resident required one staff assist with bathing, toileting, mobility - remind resident to use walker when ambulating and stability, provide physical assistance to and from meals and activities. Resident needs assistance with behaviors/mood - redirect when paces, seems agitated, use the photo books from family, provide physical assistance with dressing and physical assist to safety in an emergency. Resident uses front wheeled walker if chooses, observed resident ambulating when not using walker, encourage to slow down. Resident at risk for falls related to confusion, current falls, poor cognition and unaware of safety needs: Staff will implement the following interventions to decrease fall risk, intentional two hour rounding, increase care level/assistance, coordinated care with outside agency. Resident need one person assist with transfers.

The nurses progress notes recorded the following falls on:

8-29-16 at 9:221 p.m., found resident in memory care unit courtyard lying on left side,
9-22-16 at 8:17 a.m., found resident on floor in another resident's room,
10-13-16 at 7:45 p.m., found on floor in front of recliner in commons area,
10-23-16 at 4:45 a.m., found resident on floor in bathroom,

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S3155	Continued From page 8 10-26-16 at 1:05 a.m. found resident on floor beside bed with skin tear six centimeters (CM) on right arm, two bruises to shoulder and abrasion to mid back, 11-9-16 observed resident falling to floor, complained of right wrist pain, sent to emergency room returned to facility with splint on right wrist. Diagnoses non displaced fracture of right wrist. The NSA/HCS lacked revision to address interventions to address continued fall risk and care for resident with wrist splint. 11-14-16 at 7:00 a.m. found resident on floor, nurse called and noted large amount of bleeding from face and forehead. Resident sent to emergency room with head injury and returned with sutures in forehead. 11-15-16 resident continued to complain of pain in head due to laceration on forehead. 11-15-16 at 6:45 p.m. unwitnessed fall, stated lost balance and fell, The NSA/HCS lacked revision to address continued fall risk and care of resident following head injury with sutures. 12-22-16 8:20 p.m. Resident fell hit head on floor it bounced up and hit again on left side. Resident lying on left side and complained of pain in neck and back of head. EMS here and put cervical collar on and transferred to hospital. 1-11-17 at 12:45 p.m. kitchen staff called nurse to inform he/she observed resident on the floor on left side, 1-19-17 at 11:15 a.m. found resident on floor in bathroom and hospice nurse informed staff resident was on toilet and then left. 4-8-17 at 7:31 p.m. resident leaned over to pick	S3155		

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up domino and fell out of chair,
4-15-17 at 6:15 a.m. resident found on floor during rounds beside bed, one CM skin tear to right elbow, 2.6 CM abrasion to right knee,
5-9-17 at 11:38 p.m. found resident on floor in dining room,
7-27-17 at 6:35 p.m. observed resident fall out of chair in solarium (by commons area), the chair tipped over and resident fell to left side.

The annual FCS and NSA dated 7-31-17 recorded no changes from the 11/2016 documents; the 7-31-17 NSA/HCS added the following: resident #111 now required physical assistance with bathing provided by hospice, hospice will assist resident with dressing as needed while they are here. Check room temperature to ensure appropriate, staff to assist resident out of dining room chair after each meal and not to leave him/her unattended in dining room to prevent falls.

Interview on 11-15-17 at 1:20 p.m. with certified staff L stated resident ambulated with walker at time and does wander in and out of resident rooms.

On 11-15-17 at 1:25 p.m. observed resident ambulating in commons area using walker and in cheerful mood.

Interview on 11-15-17 at 4:45 p.m. with licensed nurse stated the computer program used generated a care plan from the NSA. Copies of NSA and NSA/HCS provided. Licensed nurse A stated and confirmed appropriate interventions not implemented for falls of cognitive impaired resident and no instructions to staff for care of fractured wrist with splint and head injuries.

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For resident #111, the licensed nurse failed to provide or coordinate health care services to meet the needs of the resident who experienced 6 falls between 8-29-16 and 11-9-16. Resident #111 fell on 11-9-16 and fractured his/her right wrist. The NSA/HCS continued to lack appropriate interventions to address resident #111's fall risk and care related to his/her fractured wrist. Resident #111 fell 6 days later on 11-14-17 and received sutures for a head laceration. The nurse further failed to provide or coordinate health care services to address the ongoing fall risk, care of the laceration and the resident fell twice the following day (11-15-17) and required emergency transport to the hospital for neck pain and pain in the back of the head. The resident experience 7 additional falls before the NSA/HCS was amended.

- Record review for resident #100 revealed an admit date of 6-5-15 with diagnoses dementia, type 2 diabetes, and hypertension.

The annual Functional Capacity Screen (FCS)'s dated 6-30-16 and 5-20-17 recorded resident required supervision with eating, physical assistance with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short term memory loss, memory recall, decision making, and falls/unsteadiness.

The annual Negotiated Service Agreement (NSA) dated 6-30-16 recorded resident required one person assist with all activities of daily living, including incontinence management and may self-propel wheelchair or use walker if able.

The annual NSA/HCS dated 8-12-16 recorded resident has aphasia and is sometimes understandable. One person minimal assistance

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with transfers, caregiver will use walker during transfer assistance. Resident needs assistance with transfers, dressing, and one person assistance with bathing. Resident required one person assist for toileting, mobility, use wheelchair during mobility assistance, provide mobility assistance to and from meals and activities, encourage to propel self in wheelchair, and physical assistance. Resident at risk for falls due to history of falls, poor cognition, incontinence, and unaware of safety needs. Staff will implement rounding, assist with regular toileting and assist with lift chair to decrease resident's risk of falls. Resident needs assistance with cognition, decision making, short term memory problems, and impaired decision making. Staff will provide re-direction, cueing for safety and care as needed. One person minimal assistance with hygiene. Resident will receive needed assistance during stay at facility.

The NSA/HCS lacked additional interventions to address the resident's ongoing risk for falls.

The nursing progress notes recorded the following 13 unwitnessed falls between 9-22-16 and 4-22-17 with resident found beside the bed unless otherwise noted below:

9-22-16 at 6:00 a.m.
10-9-16 at 6:05 a.m.
11-29-16 at 1:15 p.m.
1-1-17 at 12:20 a.m.
1-6-17 at 11:53 p.m.
1-15-17 at 10:00 p.m., found on floor outside of room,
2-22-17 at 10:26 p.m.
3-18-17 at 3:19 p.m.
4-6-17 at 3:25 p.m.
4-8-17 at 4:47 p.m.

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S3155	Continued From page 12 4-19-17 at 7:15 a.m., received nine centimeter abrasion to left buttock fall beside bed, 4-20-17 at 7:17 a.m., abrasion to both knees, 4-22-17 at 5:15 a.m. The NSA dated 5-20-17 recorded resident required one or two assist with all activities of daily living including incontinence management and may self-propel wheelchair. Assist with behavior redirection as needed. The NSA/HCS dated 5-20-17 recorded resident continued to require one person assist for dressing, bathing. Resident at risk for falls due to past history, poor cognition, incontinence, and unaware of safety needs. Staff will implement rounding, assist with regular toileting and assist with lift chair to decrease resident's fall risk. Staff will provide re-direction and cueing for safety and care as needed. The NSA/HCS plan recorded the resident now required extensive two person assist with transfers, and extensive assistance with toileting, use of wheelchair for mobility to and from meals and activities and physical assistance. Family to provide non-skid footwear, staff to check resident at 4:30 a.m., if awake toilet resident and if wants up for the day if not lay back down. Staff will provide one hour rounding the night hours and offer to assist with toileting and/or check and change during rounds. Staff to provide one person assist with hygiene. The NSA/HCS lacked additional interventions to address resident #100's ongoing risk for falls. The nursing progress notes recorded the following 7 unwitnessed falls between 6-19-17 and 11-2-17 with resident found beside the bed unless otherwise noted below:	S3155		

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(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
S3155	Continued From page 13 6-19-17 at 2:00 a.m., found in closed on floor, 7-11-17 at 4:30 a.m., found on floor, 8-31-17 at 4:19 a.m., found on floor in bathroom, 9-12-17 at 1:16 a.m., found on floor in another resident's room, 10-24-17 at 9:45 a.m. 10-24-17 at 8:00 p.m., found on floor in commons area 11-2-17 at 1:40 a.m. The fall on 10-24-17 required three staff assist to get up off floor and on 11-2-17 took four staff assist to get resident up off floor. Confidential interview on 11-9-17 stated from 12:00 noon to 6:00 a.m. only one staff on duty in each memory care unit and one certified medication aide (CMA) to administer medications for both memory care units. Since (surveyor) arrived, both memory care units have been staffed with extra staff. Interview on 11-9-17 with family member stated was not aware resident had so many falls and further stated one aide on duty to provide care leaving no other staff watching residents when the one staff member providing care to other residents. One CMA passes medication for both memory care units. Interview on 11-9-17 at 1:20 p.m. with licensed nurse A stated the staff are supposed to get a nurse to come to watch residents when they are in room providing care to another resident and further stated this is not in the HCS. Interview on 11-15-17 at 1:30 p.m. with certified staff L stated unable to locate the care plan book but resident (#100) required two person transfer	S3155		

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S3155	Continued From page 14 to wheelchair, bed, toilet, and resident is confused. For resident #100, the licensed nurse failed to provide or coordinate health care services to address this cognitively impaired residents continued risk for falls. - Record review for resident #500 revealed an admit date of 11-21-13 with diagnoses of dementia, peripheral vascular disease, edema, and atherosclerotic heart disease. The annual FCS dated 11-30-16, significant change FCS dated 3-14-17 and annual FCS dated 11-12-17 recorded resident required physical assist with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short term memory loss, impaired memory recall, impaired decision making, and falls/unsteadiness. The NSA's dated 11-13-16, 3-14-17, and 11-12-17 recorded resident required assistance with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, redirect/reapproach for behaviors-agitation, care refusal, and restlessness. The annual NSA/HCS dated 11-30-16 recorded resident required assistance with bathing and hospice will bath resident two times a week. Facility staff will provide one person assist with dressing. Resident needs assistance with mobility and staff will encourage use of walker, provide reminders to use call pendant to ask for assistance when ambulating, use wheelchair during ambulation when needed. Resident needs	S3155		

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S3155	Continued From page 15	S3155		

assistance one staff for toileting/incontinence, monitor and assist with incontinence as needed. Resident needs assistance with transfers and staff to use walker/wheelchair during transfer assistance.

The significant change NSA/HCS dated 4-24-17 added the following: provide mobility assistance to and from meals and activities, assist resident with toileting around 7:00 a.m. to 7:30 a.m. to reduce the risk of resident taking self, hospice to provide bedside commode. Resident at risk for safety concerns related to history of falls: Staff to provide/assist resident with appropriated required devices for transfers, mobility ect. (no devices listed in HCS) Us wheelchair for most mobility needs. Resident has a hi/low bed to reduce risk of serious injury related to falls. Ensure residents wheelchair is locked next to the bed. Staff to check on resident frequently. (No description of how often frequently means) in HCS.

The annual NSA/HCS dated 11-12-17 added the following: Hospice will assist resident with bathing one time weekly and floor staff will assist with shower one time weekly. Physical assistance required.

The nurses progress notes recorded the following falls on:

12-15-16 at 8:20 a.m. resident found on floor in bedroom with head next to foot of bed. Resident stated, "I was trying to get out of bed to do something last night and fell...I hit my elbow and both knees hurting." Pain scale rated at 7 on scale of 1 to 10 (10 being the worst pain). Incident note recorded at 10:46 a.m. recorded resident also stated, "I just stayed on floor to sleep since I couldn't get back up and my call

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light is over there." Resident had left call pendant on night stand.

12-28-16 (no time) Staff notified this nurse that resident was on floor next to bed and resident stated, "I don't know what I was doing." Denies pain. Assisted back to be and reminded resident to use wrist alarm and ask staff for help.

2-2-17 at 1:20 p.m. Notified resident was found on floor next to bed. Resident alert but confused as normal. Resident unable to recall why or how he/she fell.

2-4-17 at 9:44 a.m., Made signs to remind resident to call for assistance and talked with hospice about a hospital bed for resident.

(NSA/HCS) lacked interventions for sign in room.

2-4-17 at 10:04 p.m. Resident found on floor in laundry room/closet area lying on left side. Resident stated "I was trying to get to bathroom and tried to get up and fell out of bed, then crawled over to here." Observed redness to both knees and bottom of hands pink in color.

2-14-17 at 11:12 p.m. Resident found on floor lying next to bed. Resident stated, "I was trying to go to the bathroom and the next thing I know here I am on the floor." Intervention check resident for toileting every two hours and ask resident to press call button and wait for staff before he/she tries to get up. Spoke to hospice nurse about hospital bed being too high in lowest position and hand rail in an inconvenient and unsafe place. Director of nurses notified.

(NSA/HCS) lacked interventions for hand rail/side rail.

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S3155	Continued From page 17 2-15-17 at 5:00 p.m. Notified by staff resident was on floor, resident had fallen in hall bathroom. The resident had been taken to the bathroom by staff and was reported to have been given the emergency pull string and instructed to pull it when had finished using the bathroom. Resident was on the floor close to the door with back against the trash can with clothing pulled up. No complain of pain. Staff member instructed to stay with resident during toileting. (NSA/HCS) lacked interventions/instructions for staff to stay with resident when toileting. 2-15-17 at 11:03 p.m. Staff answered resident's call pendant and found resident on floor. Resident unable to recall what happened. Resident unable to stand or bear weight. Denied pain from fall. Unsteady while pivoting to sit on toilet. 3-2-17 at 9:13 a.m. Resident found in bedroom floor, small abrasion to left shin. Resident did not recall how or why he/she fell but told staff on duty he/she had been there for a long time. Staff instructed to continue checking and toileting resident every two hours and not leave resident alone for long periods in room. (NSA/HCS) lacked instructions/interventions to not leave resident alone in room for "long periods." 3-6-17 at 11:03 p.m. resident found on floor in front of washer and stated was putting clothes in dryer, lost balance and fell. No injuries. 3-8-17 at 8:40 a.m. Resident found on floor next to bed and stated was changing clothes, legs	S3155		

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gave out and I fell. I have been sitting here for an hour and forgot to use wrist call pendant. No injuries.

3-10-17 at 4:30 a.m. This nurse answered call pendant at 4:30 a.m. Upon entering room observed resident sitting on floor next to bed. Resident stated, "I slid out of bed." Reminded resident to use call pendant before getting up on own.

3-10-17 at 5:10 p.m. This nurse was notified that an (outside agency) would be here 3-12-17 to stay with resident from 9:00 p.m. to 5:00 a.m. and may be here Saturday but could not confirm.

The NSA/HCS lacked instructions/interventions to inform staff a sitter would be with resident and what the sitter would do for resident.

4-10-17 at 9:27 p.m. Resident found on floor in living room next to recliner. Resident stated, "I was trying to get into my wheelchair and I didn't make it. I fell on right hip" Wheelchair not locked and assisted resident up with 3 staff. No complaint of injuries.

5-22-17 at 8:00 a.m. Resident found on floor by washer/dryer in hallway of room. Resident stated was trying to take clothes out of the dryer to put them away. Wheelchair beside resident and foot pedals off on floor. Observed redness to right shoulder area, scrape to mid lower back, abrasion to right elbow with skin tear 3.5 CM. No other injuries.

5-27-17 at 9:21 p.m. Staff witnessed resident slide out of recliner onto floor. Staff went to administer medications and observed resident sliding out of recliner onto floor. No injuries.

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S3155	Continued From page 19 Instructed resident to call for assistance before getting up on own. 6-8-17 (no time) resident needing one staff assist to sit up at the side of bed. Resident unable to go from laying position to sitting position without assistance. Required on staff assistance to go from sitting to standing position from bed and from wheelchair to toilet. Resident also required one person assist with dressing and providing incontinent care. 7-29-17 at 2:45 a.m. this nurse answered resident's call pendant and observed resident on floor by dresser. Resident stated, "I went to restroom and couldn't make it back to the bed and ended up down here, so I had to call you." Resident complained of discomfort to back of head. Noted contusion approximately the size of a quarter on back side of head. The contusion is red and purple in color and swollen. Resident stated did not know if hit head. Alert and oriented to self but confused. Neuro checks started and resident assisted to bed and reminded to call for assistance before getting out of bed on own. Resident stated, "I didn't know I was supposed to do that." This nurse showed resident the reminders to call on pendant for assistance that are posted around room. The (NSA/HCS) lacked instructions/interventions to post signs to remind resident to call on pendant for assistance. 9-29-17 at 7:00 a.m. Resident found on floor beside bed with wheelchair beside him/her. Resident stated, "I had to go to bathroom." Redness noted to both knees. No other injuries. Interview on 11-15-17 at 3:00 p.m. with resident	S3155		

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S3155	Continued From page 20 stated had fallen several times lately and wears a bracelet to call for help. Resident stated never had anyone stay with him/her at night. Resident not able to state date, day of week, and further stated did not need to call for help when getting up or going to the bathroom as he/she does that by self. Interview on 11-15-17 at 3:05 with certified staff L stated resident required one staff assist with transfer, toileting, dressing, incontinent care and toilets resident every two hours. Certified staff L did not recall a sitter staying with resident when he/she was on duty. Interview on 11-15-17 with licensed nurse A stated resident had a sitter from an outside agency that stayed with resident a couple of nights. Licensed nurse A further stated he/she did not have any documentation that identified a sitter was with resident and the NSA/HCS lacked instructions/interventions staff and sitter to follow. For resident #500 who experienced 19 falls between 12-28-16 and 9-29-17, the licensed nurse failed to provide or coordinately appropriate health care services to address this cognitively impaired resident's ongoing risk for falls.	S3155		
S3200 SS=D	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	S3200		

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S3200	Continued From page 21 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 facility identified a census of 90 residents. The sample included 6 residents. Based on record review, interview, and observation for 1 (#300) of 6 residents sampled, the administrator failed to ensure that all medications are administered to that resident in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations. Findings included: - Record review on 11-14-17 at 11:00 a.m. for resident #300 revealed an admit date of 6-8-17 with diagnoses of depressive disorder, osteoarthritis, osteoporosis and insomnia. The functional capacity screen dated 6-19-17 recorded resident unable to manage medications. The negotiated service agreement dated 6-12-17 recorded resident will receive required medication assistance and the Certified Medication Aide	S3200		

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S3200	Continued From page 22 (CMA), or licensed nurse will administer medications. The physician's order note dated 11-6-17 at 9:46 p.m. recorded, "Zaroxolyn (Metolazone) 2.5 Milligrams (MG) give 1 tablet orally one time a day for fluid retention. Lasix 20 MG for fluid retention one time a day and potassium 20 Millequivalents (MEQ) one time a day for vitamin/mineral deficiency. The nurses progress notes recorded on 11-8-17 and 11-9-17 zaroxolyn, lasix, and potassium not available. "On 11-10-17 at 9:59 a.m., have not received lasix, zaroxolyn, or potassium from pharmacy-called to check on status of delivery. Informed that resident's card was declined and pharmacy called durable power of attorney. Physician notified and ordered to start new orders when delivered." 11-11-17 at 9:24 a.m.,. "Resident has three plus pitting edema to bilateral lower extremities with two pin sized blisters to upper right calf. Medication not available with numerous calls made to family member." 11-13-17 at 8:36 a.m. "Potassium not available." Review of Medication Administration Record (MAR) dated November 1st through 30th revealed zaroxolyn 2.5 MG administered on 11-14-17 at 12:00 noon, lasix 10 MG administered at 8:00 a.m. and potassium 20 Meq administered at 8:00 a.m. On 11-15-17 at 1:00 p.m. observed resident #300 to have three plus pitting edema with small blisters on both lower extremities.	S3200		

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S3200	Continued From page 23 Interview on 11-15-17 at 4:25 p.m. with licensed nurse A stated and confirmed received a written order for zaroxolyn 2.5 MG, lasix 10 MG, and potassium 10 MEQ on 11-6-17 and medication was not administered until 11-14-17. Resident had three plus pitting edema with blisters on upper right calf on 11-11-17. For resident #300, the administrator failed to ensure that all medications are administered to that resident in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations.	S3200		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced	S3280		

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S3280	Continued From page 24 by: KAR-26-41-104(d) The facility identified a census of 90 residents. The sample included 6 residents. Based on record review and interview for all residents, the administrator failed to ensure a quarterly review of the facility's emergency management plan with residents and further failed to review entire quarterly disaster preparedness review with staff. Findings included: - Review of quarterly disaster preparedness on 11-8-17 at 2:00 p.m. with administrator revealed he/she reviewed fire safety and prevention, tornado watch/warning, and power outage with staff who signed an employee signature sheet. The records for quarterly disaster preparedness plan lacked documentation to indicate residents reviewed the quarterly disaster preparedness plan. Interview on 11-8-17 at 3:30 p.m. with administrator stated he/she reviewed fire safety and prevention, tornado watch/warning and power outage with staff for quarterly review of disaster preparedness plan and reviewed fire drill with residents annually. The administrator failed to ensure a quarterly review of the facility's emergency management plan with residents and further failed to review entire quarterly disaster preparedness review with staff.	S3280		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a	S3310		

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S3310	Continued From page 25 communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility identified a census of 90 residents. The sample included 6 residents and 5 personnel records reviewed. Based on 2 (Certified staff M and Licensed nurse N) of 5 personnel records reviewed, the administrator failed to ensure the facility's compliance with the department's Tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of personnel records on 11-15-27 at 11:30 a.m. with licensed nurse A and administrative staff O revealed certified staff M hired on 6-19-17 lacked a two-step TB skin test and licensed nurse N hired on 4-25-17 lacked a two-step TB skin test. Interview on 11-15-17 at 11:35 a.m. with licensed	S3310		

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S3310	Continued From page 26 nurse A stated and confirmed certified staff M and licensed nurse O records lacked a two-step TB skin test. For 2 (certified staff O and licensed nurse N) of 5 personnel records reviewed, the administrator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		