STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087162	A. BUILDING: _____ B. WING _____	C 11/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for investigation of complaint #123332 of the above home plus facility on 11/20/17, 11/21/17, 11/22/17, 11/27/17, 11/28/17, and 11/29/17.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(A) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#103) of 3 residents sampled, operator/owner/licensed nurse B failed to ensure no resident was subjected to abuse when staff members used a blanket across the resident in order to restrain and keep the resident from getting out of a chair. This failure placed resident #103 in immediate jeopardy for entrapment, harm, or injury. Findings included: - Record review for resident #103 revealed an	S5026		

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

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S5026	Continued From page 1	S5026		

admission date of 10/5/16 and diagnoses of Alzheimer's disease, anxiety, and hallucinations.

The significant change functional capacity screen (FCS) dated 2/8/17 and the annual FCS dated 10/2/17 each indicated resident was independent with transferring and required supervision with walking; experienced impaired short term memory, long term memory, memory/recall, and decision making ability; was at risk for falls; and exhibited wandering behavior.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/1/16 documented resident transferred self and ambulated independently. The NSA/HCSP lacked interventions to address resident's wandering behavior. Record contained an amended negotiated service agreement (NSA) dated 2/14/17 that documented "OK to use wheelchair at meals per (spouse's) request. Body alarm when in recliner resting (until) gets up." Amended NSA 3/8/17 documented "anti-tip wheelchair." Amended NSA 5/18/17 documented "To keep resident from entering another resident room...w/c (wheelchair) placed in doorway." NSA/HCSP dated 10/5/17 documented resident independent with walking and transferring self. The NSA continued to lack interventions to address resident's wandering behavior.

At 12:40 p.m. on 11/20/17, surveyor observed resident #103 sitting in a chair by the window in the living room. Surveyor observed resident #103 get up from chair and wander throughout facility for the rest of the afternoon. At 10:20 a.m. on 11/21/17, surveyor observed certified staff C walking with resident #103. At 10:30 a.m. on 11/21/17, licensed nurse D stated resident #103 was walking in living room, pulled on a

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S5026	Continued From page 2	S5026		

wheelchair, lost balance, and fell. Resident continued to wander throughout facility.

Per confidential interview it was reported staff members used a folded blanket with a knot tied in the ends and the knots tucked down in the chair in order to keep resident seated in the chair by the window in the living room.

During another confidential interview it was reported staff members restrained resident with the blanket in the chair.

During an interview at 2:56 p.m. on 11/21/17, operator/owner/licensed nurse B and licensed nurse D each confirmed they were aware staff members had used a blanket to restrain resident #103 in a chair and that they told staff members to not do that. Along with operator/owner/licensed nurse B and licensed nurse D, surveyor watched the facility's video recording of resident in the living room. Observed resident's spouse on 11/19/17 seat resident in the chair in the living room and feed the resident lunch, then spouse left facility and resident remained in chair. Certified staff member E then assisted resident out of chair, down the hallway and back to chair at 12:30 p.m. Surveyor unable to view due to position of camera and a table blocking view, if staff member placed a blanket around resident's waist to secure resident in chair. Observed that resident remained in the chair from 12:30 p.m. on 11/19/17 until 5:17 p.m. on 11/19/17 when certified staff F reached down on each side of resident's lap and then assisted resident to stand from chair to walk to table for evening meal. During the time from 12:30 p.m. to 5:17 p.m. while sitting in the chair resident made body movements of leaning forward and raising legs

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S5026	Continued From page 3	S5026		

up as if trying to get up from chair.

At 5:30 p.m. on 11/21/17, surveyor asked operator/owner/licensed nurse B and licensed nurse D to provide written statements to answer questions of: do you have knowledge of resident being restrained by staff members; if so when was this; which staff members; and what did you do about this.

At 5:45 p.m. on 11/21/17, surveyor received a written statement from operator/owner/licensed nurse B that last spring he/she instructed (certified staff G) not to use towel type restraint to keep resident in chair. Staff reported they restrained resident to keep resident from falling since resident became fatigued when walking. Operator/owner/licensed nurse B instructed the employee on the facility's no restraint policy.

At 5:45 p.m. licensed nurse D provided his/her written statement that within the last few months he/she told (certified staff G) not to use any kind of restraint on resident such as a blanket. Licensed nurse D documented he/she instructed all staff that facility is a no restraint facility.

During a phone interview at 10:16 a.m. on 11/22/17, operator/owner/licensed nurse B stated he/she found the blanket with a knot tied in two of the corners in the laundry room last evening. Operator/owner/licensed nurse B stated he/she was first informed by certified staff H that staff members were using this to keep (resident #103) in chair.

On 11/22/17, certified staff J provided a written statement that he/she had witnessed resident #103 restrained with a blanket knotted, tucked in chair, and draped over resident's lap. Certified

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S5026	Continued From page 4 staff J wrote that he/she removed the blanket to take resident to the bathroom and did not replace the blanket on resident after seated in chair. Certified staff J wrote that when resident was seated in chair with blanket in place and resident was asleep, he/she left the blanket across resident and tucked in chair. On 11/27/17, certified staff H provided a written statement that he/she had witnessed resident restrained in chair and had removed the blanket several times from the chair. On 11/27/17, certified staff G provided a written statement that he/she "would only put the blanket on (resident) when (resident) would be bumping/hitting head on things/wall." Operator/owner/licensed nurse B failed to ensure no resident was subjected to abuse when staff members used a blanket across resident #103 in order to restrain and keep the resident from getting out of a chair due to the resident's wandering behavior. The immediate jeopardy was corrected with the implementation of a written plan provided by operator/owner/licensed nurse B at 7:39 a.m. on 11/22/17 of: Plan of correction regarding use of restraint which included education of staff and ongoing monitoring to ensure restraints are not used. 1) (Facility) will be substantially compliant by 11/21/17 regarding use of restraints. It is the policy of (facility) that restraints are not used at any time. 2) All staff will be educated by (facility's) nurse and operator by in-service over the phone beginning 11/21/17 and completed by 11/22/17 of this policy.	S5026		

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S5026	Continued From page 5 3) (Facility) nurse or operator will monitor no use of restraints by daily random observations in the home and by video camera when out of the building beginning 11/21/17 for a period of 6 months then weekly thereafter. 4) Monthly calendar will be placed in the home to document this.	S5026		
S5028 SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S5028		

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S5028	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3)(A)(B) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 2 (#103 and #102) of 3 residents sampled, operator/owner/licensed nurse B failed to report to the department within 24 hours allegations of potential abuse and/or neglect, failed to investigate the allegations, and failed to take measures to prevent further potential abuse and/or neglect. Findings included: - Record review for resident #103 revealed an admission date of 10/5/16 and diagnoses of Alzheimer's disease, anxiety, and hallucinations. The significant change functional capacity screen (FCS) dated 2/8/17 and the annual FCS dated 10/2/17 each indicated resident was independent with transferring and required supervision with walking; experienced impaired short term memory, long term memory, memory/recall, and decision making ability; was at risk for falls; and exhibited wandering behavior. Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/1/16 documented resident transferred self and ambulated independently. The NSA/HCSP lacked interventions to address resident's wandering behavior. Record contained an amended negotiated service agreement (NSA) dated 2/14/17 that documented "OK to use wheelchair at meals per (spouse's) request. Body alarm when in recliner resting (until) gets up." Amended	S5028		

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S5028	Continued From page 7	S5028		

NSA 3/8/17 documented "anti-tip wheelchair." Amended NSA 5/18/17 documented "To keep resident from entering another resident room...w/c (wheelchair) placed in doorway." NSA/HCSP dated 10/5/17 documented resident independent with walking and transferring self. The NSA lacked interventions to address resident's wandering behavior.

At 12:40 p.m. on 11/20/17, surveyor observed resident #103 sitting in a chair by the window in the living room. Surveyor observed resident #103 get up from chair and wander throughout facility for the rest of the afternoon. At 10:20 a.m. on 11/21/17, surveyor observed certified staff C walking with resident #103. At 10:30 a.m. on 11/21/17, licensed nurse D stated resident #103 was walking in living room, pulled on a wheelchair, lost balance, and fell. Resident continued to wander throughout facility.

Per confidential interview it was reported staff members used a folded blanket with a knot tied in the ends and the knots tucked down in the chair in order to keep resident seated in the chair by the window in the living room.

During another confidential interview it was reported staff members restrained resident with the blanket in the chair.

During an interview at 2:56 p.m. on 11/21/17, operator/owner/licensed nurse B and licensed nurse D each confirmed they were aware staff members had used a blanket to restrain resident #103 in a chair and that they told staff members to not do that. Along with operator/owner/licensed nurse B and licensed nurse D, surveyor watched the facility's video recording of resident in the living room.

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S5028	Continued From page 8	S5028		

Observed resident's spouse on 11/19/17 seat resident in the chair in the living room and feed the resident lunch, then spouse left facility and resident remained in chair. Certified staff member E then assisted resident out of chair, down the hallway and back to chair at 12:30 p.m. Surveyor unable to view due to position of camera and a table blocking view, if staff member placed a blanket around resident's waist to secure resident in chair. Observed that resident remained in the chair from 12:30 p.m. on 11/19/17 until 5:17 p.m. on 11/19/17 when certified staff F reached down on each side of resident's lap and then assisted resident to stand from chair to walk to table for evening meal. During the time from 12:30 p.m. to 5:17 p.m. while sitting in the chair resident made body movements of leaning forward and raising legs up as if trying to get up from chair.

At 5:30 p.m. on 11/21/17, surveyor asked operator/owner/licensed nurse B and licensed nurse D to provide written statements to answer questions of: do you have knowledge of resident being restrained by staff members; if so when was this; which staff members; and what did you do about this.

At 5:45 p.m. on 11/21/17, surveyor received a written statement from operator/owner/licensed nurse B that last spring he/she instructed (certified staff G) not to use towel type restraint to keep resident in chair. Staff reported they restrained resident to keep resident from falling since resident became fatigued when walking. Operator/owner/licensed nurse B instructed the employee on the facility's no restraint policy.

At 5:45 p.m. licensed nurse D provided his/her written statement that within the last few months

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S5028	Continued From page 9	S5028		

he/she told (certified staff G) not to use any kind of restraint on resident such as a blanket. Licensed nurse D documented he/she instructed all staff that facility is a no restraint facility.

During a phone interview at 10:16 a.m. on 11/22/17, operator/owner/licensed nurse B stated he/she found the blanket with a knot tied in two of the corners in the laundry room last evening. Operator/owner/licensed nurse B stated he/she was first informed by certified staff H that staff members were using this to keep (resident #103) in chair.

On 11/22/17, certified staff J provided a written statement that he/she had witnessed resident #103 restrained with a blanket knotted and tucked in chair and draped over resident's lap. Certified staff J wrote that he/she removed the blanket to take resident to the bathroom and did not replace the blanket on resident after seated in chair. Certified staff J wrote that when resident was seated in chair with blanket in place and resident asleep that he/she left the blanket across resident and tucked in chair.

On 11/27/17, certified staff H provided a written statement that he/she had witnessed resident restrained in chair and had removed the blanket several times from the chair.

The department did not receive a report of this allegation of resident of abuse.

During a phone interview at 3:29 p.m. on 11/27/17, operator/owner/licensed nurse B and licensed nurse D stated they did not report or investigate the incident when they observed resident restrained in chair.

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S5028	Continued From page 10	S5028		

For resident #103, operator/owner/licensed nurse B failed to report to the department within 24 hours an allegation of potential abuse, failed to investigate the allegation, and failed to take measures to prevent further potential abuse.

- Record review for resident #102 revealed an admission date of 9/20/16 and diagnoses of gastroesophageal reflux disease, weakness, and blindness.

Functional capacity screen dated 5/23/17 indicated resident required physical assistance with transferring and walking; did not experience impaired short term memory, long term memory, and memory recall, did experience impaired decision making ability; and was at risk for falls.

Negotiated service agreement/health care service plan dated 5/23/17 documented staff members to assist resident with transferring and walking.

Record contained a radiology report dated 10/23/17 of chest X-ray indicated for resident with pain in left ribs, wheezing, and shortness of breath. X-ray report documented slightly displaced fractures of left sixth through ninth ribs. The record lacked documentation of any incidents experienced by resident that might have contributed to the rib fractures.

Nurse's notes contained an entry by operator/owner/licensed nurse B on 10/22/17 that he/she and licensed nurse D met with resident's family member to discuss concerns related to care.

During an interview at 10:25 a.m. on 11/22/17, operator/owner/licensed nurse B stated resident's family member reported during the meeting on

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S5028	Continued From page 11 10/22/17 that resident stated someone threw the resident across a table. Operator/owner/licensed nurse B stated he/she did not report and investigate the allegation. Nurse's notes contained an entry by licensed nurse D that staff reported to (operator/owner/licensed nurse B) resident found on floor beside bed. During an interview at 1:16 p.m. on 11/21/17, operator/owner/licensed nurse B stated he/she did not report or investigate the incident to rule out abuse and/or neglect. For resident #102, operator/owner/licensed nurse B failed to report to the department within 24 hours allegations of potential abuse and/or neglect, failed to investigate the allegations, and failed to take measures to prevent further potential abuse and/or neglect.	S5028		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a)	S5155		

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S5155	Continued From page 12 The facility reported a census of 8 residents. The sample included 3 residents. Based on record review, interview, and observation for 3 (#101, #103, and #102) of 3 residents sampled, operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #101 revealed an admission date of 10/4/17 and diagnoses of dementia and non-insulin dependent diabetes mellitus. Functional capacity screen dated 10/3/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; independent with eating; unable to perform management of medications and treatments; was occasionally incontinent of urine; experienced impaired short term memory and long term memory; was at risk for falls; exhibited socially inappropriate disruptive behaviors; and required a walker or wheelchair for mobility. Negotiated service agreement/health care service plan (NSA/HCSP) dated 10/4/17 documented services provided by facility of physical assistance with bathing, dressing, and toileting; two-person transfer assistance; ambulation assistance of two staff members with walker and gait belt; incontinence care; fall interventions of sensor pad in bed and chair; and "preventive skin care." The NSA documented the name of a hospice provider.	S5155		

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S5155	Continued From page 13 At 1:00 p.m. on 11/20/17, hospice nurse K stated he/she assisted certified staff L and certified staff M to transfer resident to the toilet because resident had difficulty transferring. Hospice nurse K stated resident needed a sit-to-stand lift for transferring and would try to obtain the lift for resident. Hospice nurse K stated resident had behavior of hitting staff members during care. At 12:30 p.m. on 11/21/17, in the resident's room, surveyor observed operator/owner/licensed nurse B and certified staff C transfer resident from bed to wheelchair. Resident sat on edge of bed with gait belt around waist and operator/owner/licensed nurse B and certified staff C lifted resident to stand but resident did not assist by standing. Resident's feet slid forward as operator/owner/licensed nurse B and certified staff C lifted resident into wheelchair. Surveyor observed a gauze wrap on left wrist extending below resident's shirt sleeve. At 2:47 p.m. on 11/21/17, certified staff C stated gauze wrap was covering a skin tear that resident received when being transferred to bed on the previous shift. Operator/owner/licensed nurse B removed the gauze wrap from the resident's lower left arm and surveyor observed an open area approximately 2 centimeters in diameter on anterior lateral left forearm. During a phone interview at 10:16 a.m. on 11/22/17, operator/owner/licensed nurse B stated resident received skin tear when certified staff H transferred resident from recliner to wheelchair at 3:00 a.m. 11/21/17. Operator/owner/licensed nurse B stated certified staff H used another resident's sit-to-stand lift without assistance of another staff member to transfer resident who	S5155		

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resisted care and received a skin tear.

Review of resident's 10/1/17 through 10/31/17 medication administration record revealed resident received one dose of Haldol (antipsychotic) 0.5 milligrams (mg) on an as needed basis for agitation on October 4, 5, 8, 10, 18, 19, and 26, 2017 and 2 doses on October 9 and 13, 2017. Resident received Seroquel (antipsychotic) on an as needed basis for "increased dementia/behaviors/agitation" 12.5 mg on October 5, 2017 and 25 mg on October 5, 8, 9, 10, 11, 13, 14, 19, and 26, 2017. Resident received Haldol 0.5 mg topical on an as needed basis for agitation on October 25 and 30, 2017. The November 2017 medication administration record documented resident received Haldol 0.5 mg and Seroquel 25 mg by mouth on 11/19/17 for agitation.

Resident's NSA/HCSP lacked interventions to address resident behaviors of resisting care.

During an interview at 1:53 p.m. on 11/20/17 operator/owner/licensed nurse B stated resident had skin breakdown on buttocks caused by pressure and hospice nurse provided wound treatment. Operator/owner/licensed nurse B stated he/she had not assessed the resident's skin for breakdown.

During the observed transfer of resident at 12:30 p.m. on 11/21/17, in the resident's room, surveyor observed certified staff C remove the incontinence brief from the resident when he/she and operator/owner/licensed nurse B lifted resident up from sitting position. Certified staff C confirmed the resident had been incontinent of urine. Certified staff C did not provide incontinence skin care to resident.

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S5155	Continued From page 15 Resident's NSA/HCSP lacked interventions to address wound healing and prevention of further skin breakdown. During an interview at 3:19 p.m. on 11/21/17 operator/owner/licensed nurse B and licensed nurse D each confirmed the resident's NSA/HCSP lacked interventions to address resident's behaviors and risk for skin breakdown. Operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #101and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #103 revealed an admission date of 10/5/16 and diagnoses of Alzheimer's disease, anxiety, and hallucinations. The significant change functional capacity screen (FCS) dated 2/8/17 and the annual FCS dated 10/2/17 each indicated resident was independent with transferring and required supervision with walking; experienced impaired short term memory, long term memory, memory/recall, and decision making ability; was at risk for falls; and exhibited wandering behavior. Resident's record contained a negotiated service agreement/health care service plan (NSA/HCSP) dated 11/1/16 and an NSA/HCSP dated 10/5/17 that each documented resident transferred self and ambulated independently. Each NSA/HCSP lacked interventions to address resident's wandering behavior. At 12:40 p.m. on 11/20/17, surveyor observed	S5155		

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resident #103 sitting in a chair by the window in the living room. Surveyor observed resident #103 get up from chair and wander throughout facility for the rest of the afternoon. At 10:20 a.m. on 11/21/17, surveyor observed certified staff C walking with resident #103. At 10:30 a.m. on 11/21/17, licensed nurse D stated resident #103 was walking in living room, pulled on a wheelchair, lost balance, and fell. Resident continued to wander throughout facility.

Per confidential interview it was reported staff members used a folded blanket with a knot tied in the ends and the knots tucked down in the chair in order to keep resident seated in the chair by the window in the living room.

During another confidential interview it was reported staff members restrained resident with the blanket in the chair.

During an interview at 2:56 p.m. on 11/21/17, operator/owner/licensed nurse B and licensed nurse D each confirmed they were aware staff members had used a blanket to restrain resident #103 in a chair and that they told staff members to not do that.

During a phone interview at 3:29 p.m. on 11/27/17, licensed nurse D stated resident fell this date when he/she sat on foot rest of a recliner. Licensed nurse D stated resident walked until tried which increased resident's risk for falls.

Resident's NSA/HCSP lacked interventions to address resident's wandering behavior and risk for falls due to wandering.

Operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the

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provision of necessary health care services that met the needs of resident #103 and were in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #102 revealed an admission date of 9/20/16 and diagnoses of gastroesophageal reflux disease, weakness, and blindness.

Functional capacity screen dated 5/23/17 indicated resident required physical assistance with transferring and walking; supervision with eating, was unable to perform management of medications and treatments; did not experience impaired short term memory, long term memory, and memory recall, did experience impaired decision making ability; and was at risk for falls.

Negotiated service agreement/health care service plan dated 5/23/17 documented staff members to assist resident with transferring and walking; at meal time serve food in a scoop plate and assist resident with feeding self as needed; and facility management and administration of medications and treatments.

Nurse's notes contained an entry by operator/owner/licensed nurse B on 10/22/17 that he/she discussed resident's weight loss with medical care provider and received order for a dietary supplement.

Resident's record contained a medical care provider's order dated 10/22/17 for dietary supplement offer 1 can daily related to weight loss and weigh resident weekly until further orders.

The resident's weight record documented

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S5155	Continued From page 18 resident weighed 96 pounds on 10/25/17 and 94 pounds on 11/5/17. Resident's record lacked documentation of a weekly weight after 11/5/17. During an interview at 12:57 p.m. on 11/21/17, operator/owner/licensed nurse B confirmed a licensed nurse did not monitor the resident's weight on a weekly basis. Operator/owner/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #102 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 (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 8 residents. The sample included 3 residents. Based on record review and interview for 1 (#101) of 3 residents sampled, operator/owner/licensed nurse B 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.	S5251		

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S5251	Continued From page 19	S5251		

Findings included:

- Record review for resident #101 revealed an admission date of 10/4/17 and diagnoses of dementia and non-insulin dependent diabetes mellitus.

Functional capacity screen dated 10/3/17 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility; experienced impaired short term memory and long term memory; was occasionally incontinent of urine; was at risk for falls; exhibited socially inappropriate disruptive behaviors; and utilized a walker or wheelchair for mobility.

Negotiated service agreement/health care service plan dated 10/4/17 documented physical assistance with activities of daily living.

The resident roster indicated resident had a skin problem.

During an interview at 1:53 p.m. on 11/20/17 operator/owner/licensed nurse B stated resident had skin breakdown on buttocks for the last 2 weeks caused by pressure.

Further review of resident's record revealed the lack of documentation of the presence of a wound on buttocks, action taken and results of the action.

At 1:59 p.m. on 11/22/17, operator/owner/licensed nurse B confirmed the resident's record lacked documentation of the presence of a wound.

On 10/11/17, resident's medical care provider

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S5251	Continued From page 20 documented a visit to resident as a "fall follow-up" with possible injury to left arm. Medical care provider documented X-ray negative for fracture. Resident's record lacked documentation of resident falling including the date, time of occurrence, action taken, and results of the action. During an interview at 2:05 p.m. on 11/20/17, operator/owner/licensed nurse B confirmed the resident's record lacked documentation of resident's fall. Operator/owner/licensed nurse B failed to ensure resident #101'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.	S5251		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S5300		

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S5300	Continued From page 21 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 1 (#101) of 3 residents sampled, operator/owner/licensed nurse B failed to ensure a medication was administered to the resident in accordance with professional standards of practice. Findings included: - Record review for resident #101 revealed an admission date of 10/4/17 and diagnoses of dementia and non-insulin dependent diabetes mellitus. Functional capacity screen dated 10/3/17 indicated resident was unable to perform management of medications. Negotiated service agreement dated 10/4/17documented staff members administered medications to resident. Review of the October 2017 medication administration record (MAR) revealed the following entries for Seroquel (an antipsychotic medication): Page two of the MAR contained and entry for Seroquel 25 milligrams (mg) tablet, take 1 tablet by mouth three times a day for dementia/behaviors with scheduled times of 7:00 a.m., 1:00 p.m., and 5:00 p.m. The MAR	S5300		

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S5300	Continued From page 22	S5300		

contained initials to indicate resident received the medication at 7:00 a.m. daily 10/5/17 through 10/13/17, the 1:00 p.m. dose 10/4/17 through 10/14/17 and the 5:00 p.m. dose on 10/4/17. The 5:00 p.m. time was then marked out and 9:00 p.m. written as the time for the third dose of the day and initialed as administered 10/5/17 through 10/12/17. Directly below this entry was a handwritten entry for "Seroquel: Increase to 50 mg po (by mouth) @ 0700 (7:00 a.m.) and 2100 (9:00 p.m.) continuous 150 mg @1600 (4:00 p.m.)." The area for documentation of medication administration contained written information that order was changed 10/13/17 and lacked documentation medication was administered.

The October 2017 MAR also contained an entry on page 4 of Seroquel 25 mg 1 tablet by mouth at 1:00 p.m. The entry lacked documentation the medication was administered but contained written information to see page one, order changed. Page one did not contain an entry for a 1:00 p.m. dose but did contain an entry for Seroquel 100 mg, take 1 and 1/2 tablet (150 mg) by mouth daily before dinner at 4:00 p.m.

The October 2017 MAR included an unnumbered page that contained the following handwritten entries:

Seroquel 25 mg by mouth two times a day at 7:00 a.m. and 9:00 p.m. with order start date of 10/13/17 and documentation of medication administered at 7:00 a.m. 10/14/17 through 10/31/17 and 9:00 p.m. 10/13/17 through 10/31/17.

Seroquel 50 mg 1 tablet daily by mouth at 1:00 p.m. with documentation medication administered 10/14/17 through 10/31/17.

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S5300	Continued From page 23 Seroquel 150 mg by mouth daily at 4:00 p.m. The entry included that 1 1/2 tablet equaled 150 mg. This entry lacked documentation that this dose was administered but contained handwritten information of "See next page." Page 3 of the October MAR contained an entry of Seroquel 25 mg tablet, take 1/2 tablet by mouth daily as needed for increased dementia/ behaviors/agitation. The entry contained a handwritten line through 1/2 tablet and handwritten in 1 tablet and 25 mg 1 tablet. The November 2017 MAR contained the following entries on page one: Seroquel 100 mg, take 1 and 1/2 tablet (150 mg) by mouth daily before dinner at 4:00 p.m. This entry contained a handwritten line through 1/2 tablet and 100 mg written over the crossed out 150 mg. Order changed 11/7/17 handwritten in the entry. The MAR contained documentation resident received Seroquel at 4:00 p.m. 11/1/17 through 11/19/17. Unable to determine from the MAR if resident received a 150 mg dose or a 100 mg dose with each dose administered. Seroquel 25 mg take 2 tablets (50 mg) by mouth daily at 1:00 p.m. This entry contained a handwritten line through "2" and changed to "1" tablet and a line through "50 mg" changed to "25 mg" and order changed 11/7/17. The MAR contained documentation resident received Seroquel at 1:00 p.m. 11/1/17 through 11/20/17. Unable to determine from the MAR if resident received a 50 mg dose or a 25 mg dose with each dose administered. During an interview at 2:06 p.m. on 11/20/17,	S5300		

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S5300	Continued From page 24 operator/owner/licensed nurse B stated when medical care provider changed dosages and frequency of Seroquel licensed and certified staff did not transcribe the new order with a new entry for the medication on the MAR and did not discontinue the previous entry on the MAR. Operator/owner/licensed nurse B failed to ensure a medication was administered to resident #101 in accordance with professional standards of practice.	S5300		
S5335 SS=E	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 2 (#103 and #101) of 3 residents sampled and 2 (#104 and #105) non-sampled residents, operator/owner/licensed nurse B failed to ensure the facility was maintained to protect the health and safety of residents when a wheelchair was used to block the doorway to resident rooms.	S5335		

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S5335	Continued From page 25	S5335		

Findings included:

- Record review for resident #103 revealed an admission date of 10/5/16 and diagnoses of Alzheimer's disease, anxiety, and hallucinations.

The significant change functional capacity screen (FCS) dated 2/8/17 and the annual FCS dated 10/2/17 each indicated resident was independent with transferring and required supervision with walking; experienced impaired short term memory, long term memory, memory/recall, and decision making ability; was at risk for falls; and exhibited wandering behavior.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/1/16 documented resident transferred self and ambulated independently. The NSA/HCSP lacked interventions to address resident's wandering behavior. Record contained an amended negotiated service agreement (NSA) dated 2/14/17 that documented "OK to use wheelchair at meals per (spouse's) request. Body alarm when in recliner resting (until) gets up." Amended NSA 3/8/17 documented "anti-tip wheelchair." Amended NSA 5/18/17 documented "To keep resident from entering another resident room...w/c (wheelchair) placed in doorway." NSA/HCSP dated 10/5/17 documented resident independent with walking and transferring self. The NSA continued to lack interventions to address resident's wandering behavior.

At 11:52 a.m. on 11/21/17, when surveyor asked about the 5/18/17 amended NSA regarding a wheelchair in resident doorway, licensed nurse D stated at night staff members placed a wheelchair in the doorway of the room of resident #101, resident #104, and resident #105 to keep resident

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S5335	Continued From page 26 #103 from entering those rooms. At 12:40 p.m. on 11/20/17, surveyor observed resident #103 sitting in a chair by the window in the living room. Surveyor observed resident #103 get up from chair and wander throughout facility for the rest of the afternoon. At 10:20 a.m. on 11/21/17, surveyor observed certified staff C walking with resident #103. At 10:30 a.m. on 11/21/17, licensed nurse D stated resident #103 was walking in living room, pulled on a wheelchair, lost balance, and fell. Resident continued to wander throughout facility. During time in the facility on 11/20/17 and 11/21/17, surveyor observed residents #101, #104, and #105 required physical assistance with transferring and mobility. Operator/owner/licensed nurse B failed to ensure the facility was maintained to protect the health and safety of residents when a wheelchair was used to block the doorway to resident rooms.	S5335		