STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087218	A. BUILDING: _____ B. WING _____	R 11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FUSION SENIOR CARE HOMES LLC	512 N BEBE STREET WICHITA, KS 67212

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 17-122 and ban on admissions 17-19 of the above home plus facility on 11/29/17 and 11/30/17.	{S 000}		
{S5155} SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 2 (#4007 and #4006), 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 #4007 revealed an admission date of 11/22/16 and diagnosis of type 2 diabetes mellitus.	{S5155}		

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

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{S5155}	Continued From page 1 Functional capacity screen dated 11/24/17 indicated resident required physical assistance with transferring and mobility; was at risk for falls; and experienced impaired short term memory and memory recall. The record contained an addendum to negotiated service agreement dated 7/10/17 that documented the service of "bed rail at night for safety (3/4/rail)." The current negotiated service agreement/health care service plan dated 11/24/17 lacked a description of the resident's need for a bed rail including resident's ability to safely use the bed rail and the safety of the device. During a phone interview at 10:42 a.m. on 11/30/17, licensed nurse C stated resident continued to use a bed rail at night. 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 #4007 and were in accordance with the functional capacity screening and the negotiated service agreement. - Record review for resident #4006 revealed an admission date of 10/21/17 and diagnoses of urinary tract infection, paranoid schizophrenia, and anxiety. Significant change functional capacity screen dated 11/24/17 indicated resident experienced impaired long term memory and decision making ability; was independent with eating; and unable to perform management of medications and medical treatments. Record contained a medical care provider's order	{S5155}		

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{S5155}	Continued From page 2 dated 10/21/17 to monitor and record resident's intake of fluids and output of urine. Resident's record lacked documentation of intake of fluids and output of urine. Negotiated service agreement/health care service plan dated 11/24/17 lacked a description of the monitoring and recording of fluid intake and urine output. During an interview at 2:14 p.m. on 11/29/17, licensed nurse C stated staff members discontinued monitoring and recording fluid intake and urine output when resident finished taking an antibiotic for a urinary tract infection. Review of the November 2017 medication administration record revealed resident finished antibiotic 11/4/17. Licensed nurse C stated he/she did not obtain a medical care provider's order to discontinue monitoring and recording of fluid intake and urine output. 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 #4006 and were in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
{S5225} SS=E	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the	{S5225}		

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{S5225}	Continued From page 3 following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(a) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for all residents, operator/owner/licensed nurse B failed to maintain a safe, sanitary, and comfortable environment for residents. Findings included: - Record review for resident #4008 revealed an admission date of 4/1/17 and diagnoses of essential hypertension, type 2 diabetes mellitus, chronic kidney disease, neuropathy, and osteoarthritis. Record contained a functional capacity screen (FCS) dated 4/1/17 and an FCS dated 11/28/17 that each indicated resident required physical assistance with bathing, dressing, transferring, and toileting. The 11/28/17 FCS indicated resident was unable to walk or mobilize self. Record contained a negotiated/health care service plan (NSA/HCSP) dated 4/1/17 and an NSA/HCSP dated 11/28/17 that each	{S5225}		

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{S5225}	Continued From page 4	{S5225}		

documented facility staff members provided assistance with bathing, dressing, toileting, transferring, and mobility in wheelchair.

Record contained documentation by licensed nurse C 11/15/17 "Observation by staff of bed bug on resident. Inspection by exterminator and noting of prevalence of numerous bugs on (resident's) wheelchair. Wheelchair was treated with chemical, washed, and vacuumed and put back in service."

At 3:12 p.m. on 11/29/17, licensed nurse C stated he/she based his/her 11/15/17 documentation in the resident's record based on the staff member's report of bed bug on resident and bed bugs on wheelchair. At 3:19 p.m. licensed nurse C stated he/she did not come to facility and assess the resident for bites from bed bugs.

Owner/operator/licensed nurse B provided the facility's "Policy and Procedure on Bed Bugs" Review of this revealed the lack of a process for staff members to follow to ensure resident and resident's clothing free of bed bugs including a procedure to prevent spreading the infestation throughout the facility. Operator/owner/licensed nurse B provided an exterminator's service inspection report dated 11/15/17 at 5:56 p.m. of treatment applied to the interior targeting bed bugs. This report documented no pest activity noted. Operator/owner/licensed nurse B also provided an exterminator's service inspection report dated 11/20/17 at 4:53 p.m. of treatment applied to the interior targeting bed bugs. This report documented "resolved this visit."

During an interview at 3:16 p.m. on 11/29/17, when surveyor asked what staff members were to do to ensure resident and resident's clothing free

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{S5225}	Continued From page 5 of bed bugs and to prevent spreading the infestation, operator/owner/licensed nurse B stated wash and dry clothing for resident to put on after resident washed hair and showered and staff member to wash and dry all of resident's clothing from resident's room. Operator/owner/licensed nurse B stated after staff members vacuumed the resident's room and furniture, canister of vacuum cleaner should be emptied into a plastic trash bag, closed and taken out of facility. Operator/owner/licensed nurse C confirmed the policy and procedure did not specify these instructions. For all residents, operator/owner/licensed nurse B failed to maintain a safe, sanitary, and comfortable environment for residents	{S5225}		
{S5300} SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	{S5300}		

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{S5300}	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 2 (#4008 and #4007) of 3 residents sampled, operator/owner/licensed nurse B failed to ensure all medications and biologicals were administered to residents in accordance with a medical care provider's written orders and professional standards of practice. Findings included: - Record review for resident #4008 revealed an admission date of 4/1/17 and diagnoses of essential hypertension, type 2 diabetes mellitus, chronic kidney disease, neuropathy, and osteoarthritis. Record contained a functional capacity screen (FCS) dated 4/1/17 and an FCS dated 11/28/17 that each indicated resident unable to perform management of medications. Record contained a negotiated/health care service plan (NSA/HCSP) dated 4/1/17 and an NSA/HCSP dated 11/28/17 that each documented licensed staff and certified medication aides administered medications to resident and a home health nurse administered insulin injections. Review of the resident's medication administration record (MAR) for dates 11/9/17 through 11/28/17 revealed the lack of documentation that resident received the following medications as ordered by the medical	{S5300}		

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{S5300}	Continued From page 7	{S5300}		

care provider:

Macrobid (antibiotic prescribed to treat resident's urinary tract infection) 100 milligrams (mg) one capsule by mouth every 12 hours for 5 days (10 doses) starting at 8:00 p.m. on 11/13/17 and last dose 8:00 a.m. on 11/18/17. The MAR lacked documentation to indicate resident received the 8:00 a.m. dose on 11/15/17 and 11/16/17 and the 8:00 p.m. dose on 11/13/17, 11/15/17, and 11/16/17.

Prevacid (to treat gastroesophageal reflux disease) 30 mg one capsule by mouth daily. The MAR lacked documentation to indicate resident received a dose at 6:30 a.m. on 11/24/17.

Plavix 75 mg one tablet daily at 8:00 a.m. The MAR lacked documentation to indicate resident received a dose on 11/24/17.

Metoprolol (to treat hypertension) 25 mg take 1/2 tablet by mouth 2 times a day. The MAR lacked documentation to indicate resident received a dose at 6:00 p.m. on 11/28/17.

Gabapentin (to relieve nerve pain) 300 mg one capsule by mouth 3 times a day. The MAR lacked documentation to indicate resident received a dose at 6:00 p.m. on 11/28/17.

Hydrocodone (to relieve pain) 5-325 mg 1 tablet by mouth 3 times a day. The MAR lacked documentation to indicate resident received a dose at 6:00 p.m. on 11/18/17 and 11/28/17.

Levemir (insulin to control high blood sugar) 10 units subcutaneously at 8:00 a.m. daily. The MAR lacked documentation to indicate resident received this injection at 8:00 a.m. on 11/25/17

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{S5300}	Continued From page 8 and 11/26/17. Levemir 26 units subcutaneously at 5:00 p.m. daily. The MAR lacked documentation to indicate resident received this injection at 5:00 p.m. on 11/25/17. The MAR contained an entry for atorvastatin (to lower cholesterol) 20 mg 1 tablet by mouth daily at 8:00 p.m. The MAR contained the circled initials of a staff member on 11/28/17. Per phone interview at 10:42 a.m. on 11/30/17 with licensed nurse C, the MAR lacked documentation to explain why the staff member circled the initials. [Note: circled initials indicate resident did not receive a medication and documentation should explain the reason medication was not administered.] The MAR contained instructions to not administer metoprolol to resident if heart rate less than 60 beats per minute. The MAR lacked documentation of the resident's heart rate prior to administration of the 8:00 a.m. dose on November 10, 13, 15, 16, 17, 18, 19, 22, and 24, 2017. The MAR lacked documentation of the resident's heart rate prior to administration of the 6:00 p.m. dose on November 11, 12, 13, 15, 16, 17, 18, 19, 20, 22, 24, 25, 26, 27, and 28, 2017. The MAR contained instructions to not administer the daily dose of amlodipine 10 mg (to treat hypertension) if resident's systolic blood pressure (the upper number of a blood pressure reading) less than 120. The MAR lacked documentation of the resident's blood pressure prior to the administration of the dose on November 10, 15, 16, 17, 19, and 24, 2017. During an interview at 12:11 p.m. on 11/29/17,	{S5300}		

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{S5300}	Continued From page 9	{S5300}		

licensed nurse C confirmed the MAR lacked documentation of the above medications administered or not administered. At 3:05 p.m. on 11/29/17, licensed nurse C stated staff members instructed to document heart rate (prior to administration of metoprolol) and blood pressure readings (prior to administration prior of amlodipine) on the MAR.

At 3:20 p.m. on 11/29/17, operator/owner/licensed nurse B provided the facility's policy and procedure maintained in the policy and procedure manual for "Medication Administration." This policy and procedure did not contain instruction for the documentation of medications administered or not administered. Operator/owner/licensed nurse B then provided a document from his/her file with title of "Medication Schedule." This document also lacked instruction for documentation of medications administered or not administered.

Operator/owner/licensed nurse B failed to ensure all medications and biologicals were administered to resident #4008 in accordance with a medical care provider's written orders and professional standards of practice.

- Record review for resident #4007 revealed an admission date of 11/22/16 and diagnosis of type 2 diabetes mellitus.

Functional capacity screen (FCS) dated 7/24/17 and FCS dated 11/24/17 each indicated resident was unable to perform management of medications.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/22/16 and NSA/HCSP dated 11/24/17 each documented

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{S5300}	Continued From page 10 service of medication administration by licensed staff and certified medication aides. Review of the resident's medication administration record for dates 11/9/17 through 11/28/17 revealed the lack of documentation that resident received Tamulosin (improve urine flow) 0.4 milligram at 7:00 p.m. on 11/16/17. At 3:20 p.m. on 11/29/17, operator/owner/licensed nurse B provided the facility's policy and procedure maintained in the policy and procedure manual for "Medication Administration." This policy and procedure did not contain instruction for the documentation of medications administered or not administered. Operator/owner/licensed nurse B then provided a document from his/her file with title of "Medication Schedule." This document also lacked instruction for documentation of medications administered or not administered. Operator/owner/licensed nurse B failed to ensure all medications were administered to resident #4007 in accordance with a medical care provider's written orders and professional standards of practice.	{S5300}		