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| S 000 | INITIAL COMMENTS<br><br>The following citations are the result of complaint investigations #121384, #116397, and #116333 at the above named Residential Health Care Facility in Wichita, Kansas on 10/18/17, 10/19/17, 10/23/17, 10/24/17, 10/25/17, 10/26/17, 10/30/17, 10/31/17, 11/01/17, 11/02/17, 11/05/17, 11/06/17, 11/07/17, 11/08/17, 11/09/17. | S 000 | | |
| S3026 SS=K | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(1)(B)<br><br>The census equalled 27 the sample included five discharged Residents. Based on interviews and reviews of records, for three of five sampled (#5, #6, and #9), the Operator failed to ensure no Resident was subjected to neglect when the licensed nurse failed to assess and provide or coordinate interventions to address these cognitively impaired residents change in condition. Resident #9 experienced an incident of sudden respiratory distress during the noon meal on 9/19/17 and the licensed nurse failed to assess the resident and provide or coordinate health care services to address the coughing, | S3026 | | |

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

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expectorating, gurgling, and anxiety producing symptoms that continued until hospice arrived at 3:45pm. The licensed nurse failed to ensure adequate instruction was disseminated to all evening meal staff in regard to precautions for eating and drinking with #9's current status. Resident experienced decline in condition while in the dining room during the evening meal and expired shortly after. Resident #6 discovered with cough, wheezing, and oxygen saturation level of 83% by hospice 8/17/17; hospice staff and the APRN developed a treatment plan and orders were issued. The licensed nurse failed to ensure the medical care provider's orders were implemented when breathing treatments and expectorant medications were not administered as ordered and administration of oxygen and monitoring of oxygen saturation was not completed. The licensed nurse further failed to provide and coordinate services to address the resident's refusal of oxygen and failed to ensure orders received on 9/26/17 when the resident was diagnosed with acute bronchitis were implemented. The resident was diagnosed with pneumonia on 9/30/17 and died on 10/7/17. Resident #5 experienced a significant decline in condition and possible aspiration on 7/9/17 and the licensed nurse failed to assess the resident at the time of the incident, investigate to determine possible causes for the sudden change in condition, conduct follow up assessments and implement interventions to address ongoing risk for aspiration. The licensed nurse further failed follow up on diet change orders for two weeks. These failures placed residents in immediate jeopardy for harm, injury or death.

Findings included:

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- Review of record revealed #9 admitted to facility 7/08/16 with diagnoses of Alzheimer's disease, anxiety disorder, depressive disorder, hypertension, and agitation.

The current functional capacity screen of 6/14/17 assessed #9 required physical assistance with all activities of daily living (ADL) and had impaired short term memory, long term memory, memory recall and decision making.

The current negotiated service agreement (NSA) and health service plan (HSP) of 5/02/17 recorded services for all ADLs. The HSP recorded #9 on a "regular diet, feeds self sometimes with cuing but may need assistance to stay on track." A 6/14/17 NSA amendment added Hospice services for dementia and anxiety.

Nurses notes (NN) 9/5/17 at 2:59 p.m. "medical provider here for rounds,. No new orders obtained, no new concerns,. Resident is stable at this time Nursing staff will continue to monitor and floor staff will observe."

The record lacked any further facility nurses notes until 9/19/17 at 2:59 p.m.

NN dated 9/19/17 at 2:59 p.m. by facility nurse #F "Resident had episode of syncope (temporary loss of consciousness usually related to low blood pressure) during lunch today. Has not fully aroused since. PCP (primary care physician) and DPOA (durable power of attorney) and hospice notified. Resident was given PRN dose of Ativan (medication for anxiety) for increase respirations and pulse. Nursing staff will continue to monitor and floor staff will observe."

The record lacked documentation of the vital

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signs and ongoing monitoring of resident's condition.

The September MAR (medication administration record) documented doses of Ativan given at 8:42 a.m. and 4:05 p.m. on 9/19/17. The MAR lacked documentation of administration of Ativan at lunch time.

The next and final entry of NN dated 9/19/17 at 10:59pm by facility nurse #F documents "at 1814 (6:14 p.m.) hospice nurse in with Resident and notified staff that Resident expired. Hospice notified family . . ."

9/19/17 Hospice "Skilled Nursing Visit Note" (SNVN) with time in 15:45 (3:45 p.m.) time out 16:50 (4:50 p.m.) documented "Pulse 126, respirations 22 labored, blood pressure 152/94, oxygen saturation 66% room air; anxiety 10, shortness of breath 7, pain, difficulty swallowing, speech incoherent, rapid, slurred, abnormal; shallow breath sounds at rest, oxygen saturation 90% with oxygen applied; diminished breath sounds LLL(left lower lung lobe), RLL (right lower lung lobes), coarse breath sounds LUL(left upper lung lobe), RUL (right upper lung lobe), RML (right middle lung lobe). Treatment initiated opioids, oxygen, and other medications."

Hospice Narrative notes by Hospice RN (registered nurse) #E documented: "this nurse called to facility due to patient having increase secretions per med aide. . . in wheelchair, VERY agitated, gasping for air while trying to voice needs... is physically rocking back and forth in chair unable to get settled... pulse oximeter at 66% with noted cyanosis to hands and feet. Oxygen immediately administered via NC (nasal cannula) at 4L (liters). Simple mask not used due

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to secretions patient was trying to get out of mouth due to inability to swallow. This nurse helped patient clear out mouth with a towel and encouraged patient to wipe out the secretions. Staff (facility) verbalized that patient had choking episode at lunch and "ever since that time had been like this." . . . Facility nurse #F, gotten from back office and again notified of patient's condition by this nurse. Facility nurse #F asked to get Roxanol (medication used for pain and air hunger), and scopolamine (to reduce saliva) from EKIT (emergency kit containing medications ordered by hospice to treat pain, anxiety, nausea, agitation and increased secretions) as well as Ativan (antianxiety) from already standing PRN orders. Roxanol administered. Then approximately 5 minutes later the Ativan and scopolamine were administered. Call placed to APRN and family. After approximately 15 minutes patient had visibly calmed down and oxygen sat [saturation] had come up. Patient was no longer gasping for air, and eyes were no longer bulging. Patient could still not voice thoughts and was coughing up secretions but there was not any food in mouth that this nurse could see. Facility nurse #F in agreement to schedule EKIT meds. Staff educated on aspiration and precautions. This nurse left patient on 4L O2 per NC (nasal cannula) in wheelchair where he/she was calm and attempting to rest. APRN returned call and verbalized agreement of plan with no new orders noted. Visit date and time confirmed by facility nurse #F with signature captured on 9/19/17 15:58 (3:58 p.m.).

The MAR for 9/19/17 at 5:00 p.m. documented the resident received Ativan .25 mg (one half 0.5 mg tablet), Tylenol 650 mg (two 325 mg tablets) and Guiatuss syrup two tablespoons.

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| S3026 | Continued From page 5<br><br>9/19/17 hospice SNVN with time in 18:00 (6:00 p.m.), time out 20:00 (8:00 p.m.). Narrative notes of visit by Hospice RN #G documented: "Received call from facility CMA (certified medication aide) stating that patient had declined quickly and that a hospice nurse was needed right away. Stated fluid was exiting mouth and skin tone extremely pale. This nurse arrived to patient sitting in living room with oxygen on. Patient took three more breaths before TOD (time of death) noted with no heart tones and lack of respirations at 18:14 (6:14 p.m.). Was on the phone with family member. Voided of copious amounts of fluids from mouth, white and thick in color. Pallor, eyes fixed, cool to tough. Notified APRN. Assisted 2 certified nurse aides with transfer of patient into wheelchair and into bed... postmortem care... notified facility nurse #C."<br><br>By confidential interview employee #R stated #9 used to sing a lot. On 9/19/17 when #9 was eating he/she began coughing and choking and facility nurse #F was called out of the office. Facility nurse #F came and looked at #9 and said to keep an eye on him/her. Employee #R stated #9 continued to cough and spit up phlegm all the rest of the afternoon and didn't eat anymore after he/she started coughing. #9 kept looking at staff and was still alert.<br><br>By confidential interview employee #N stated #9 would basically sing a lot like in talking to you and had a usual morning but at lunch was choking and coughing with phlegm in throat. #9 had a similar episode two or three days before 9/19/17. Employee #N further stated no nurse was with resident when taken from the dining room; facility nurse #F looked at #9 when day shift charting. The day shift staff were with #9, coaxing him/her to get the phlegm out and you could hear his/her | S3026 | | |

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breathing in his/her throat.

By confidential interview employee #M stated #9 loved music and participated in activities and he/she was normal self before 9/19/17. On 9/19/17 at lunch was coughing up mucous, thick phlegm like, not vomit and was taken out of dining room. When #9 was taken out of the dining room he/she was alert, trying to clear throat. He/she continued that the rest of the day, would ask for help and staff on duty would tell him/her to spit it out. Employee #M further stated facility nurse #F was told #9 not getting any better.

By confidential interview employee #I stated he/she was not aware of any vitals taken on 9/19/17 when #9 lost consciousness for a while. Employee #I further stated hospice was called and when hospice left told staff not to take to dining room for evening meal. Later, #9 wasn't looking right and hospice was called again.

By confidential interview employee #Q stated #9 sweet to the last day and was doing fine before 9/19/17. In the afternoon (9/19/17) #9's breathing was like water in a pipe and he/she was like drooling but more than drooling that staff used a cloth towel to catch. Employee #Q further stated it was like there was fluid somewhere he/she couldn't get out but #9 was alert and looking around. Resident #9 was taken from dining room at evening meal time and didn't know if he/she had anything to eat or drink. There was a flurry of activity and they said he/she passed after six.

By confidential interview employee #U stated #9 was at the evening table, had oxygen on and was not his/her usual self. Employee #U stated #9

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was offered food and drink, wasn't taking anything and was making a gurgling noise.

By confidential interview employee #J stated when I came on duty, in report they just told me #9 aspirated and had passed.

By interview on 10/24/17 at 10:55am, facility nurse #F confirmed no NN, assessment, or documentation of actions of the coughing spell #9 experienced before 9/19/17 that led to an order for Mucinex. Facility nurse #F further confirmed NN on 9/19/17 at 2:59 p.m. is the only facility documentation for events of 9/19/17.

For Resident #9, the operator failed to ensure the resident was not subject to neglect when #9 experienced an incident of sudden respiratory distress during the noon meal on 9/19/17 and the licensed nurse failed to document ongoing assessment of the resident and provide health care services to address the coughing, expectorating, gurgling, anxiety producing symptoms that continued until hospice arrived at 3:45pm. The licensed nurse failed to demonstrate adequate instruction disseminated to all evening meal staff in regard to precautions for eating and drinking with #9's current status. Resident experienced decline in condition while in the dining room during the evening meal and expired shortly after.

- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.

The current functional capacity screen of 4/06/17

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recorded #6 required physical assistance with transfers, mobility and medication and supervision with toileting and eating. The cognition/memory recall section was incomplete.

The current negotiated service agreement (NSA) and health service plan (HSP) of 4/06/17 recorded facility staff assistance with bathing, dressing, toileting, transfer; and medication/treatment and documented #6 on a "regular diet"
A 7/26/17 NSA amendment added Hospice services for weight loss and unexplained episodes of syncope.

The Nurses Notes (NN) recorded:
8/16/17 at 10:59 p.m. by licensed nurse #C : "staff called this nurse to report that resident had a fall. This nurse came to assess. Staff reported that at 2115 (9:15 p.m.) resident's alarm sounded, when staff went to room they round resident just going onto the floor, leaned over and left side of body was against the wall, resident was also yelling for help, upon assessment, resident has skin tear to left side of forehead, skin tear to left hand 5th digit. . . , b/p (blood pressure) 166/58, pulse 64, respirations 26, temp 98.4" The note recorded licensed nurse C applied first aid to the injuries, administered Tylenol for pain and faxed the medical care provider concerning the fall.

Record lacked documentation of resident's respiratory status and notification of hospice of the fall.

8/17/17 hospice "Skilled Nursing Visit Note" (SNVN) documented in at 12:39 (12:39 p.m.) out at 13:30 (1:30p.m.) "informed by HHA (home health aide) Resident had a fall last night. This nurse out to assess. No call made to hospice

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concerning fall when it had occurred the night prior... patient is seen in dining room... in wheelchair... has prominent laceration to left scalp where steri strips applied... bruising to left lateral upper arm and elbow... verbalizes no pain... does not remember fall... vital signs are taken and oxygen saturation is low at 83%... has non-productive cough and appears to be labored in breathing... lung sounds coarse to all fields... asked three staff members for oxygen but no stock oxygen is stored... ordered from supply company... instructed staff (facility nurse #F and several certified staff) to start oxygen at 2L (liters) continuously... stressed importance of notification of any patient changes."

Medical record contained a fax physician's order obtained by the hospice nurse dated 8/17/17 and signed by the APRN (advanced practice registered nurse) on 8/17/17: Duoneb (medication for inhalation treatment to treat cough, wheezing , difficulty breathing and chest tightness) TID (three times daily) scheduled for 5 days and every 4 hours PRN and Robitussin (expectorant to help loosen congestion) 10ml (milliliters) every 4 PRN, Doxycycline (antibiotic) 100mg (milligrams) BID (twice daily) for 5 days.
.
August 2017 MAR contained the related to these orders:
- Doxycycline, start date 8/17/17. Staff initials recorded for administration of 10 doses beginning at 8:00am on 8/18/17 and ending at 5:00 p.m. on 8/22/17.

- Duoneb, start date 8/17/17, "three times a day and every 4 hours as needed." The order on the MAR failed to specify "scheduled for 5 days." The administration section for this medication was blank and lacked documentation this medication

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was ever administered.

-The MAR included an order for Robafen-DM (a cough suppressant medication) syrup, start date 8/17/17, "take 10ml (milliliters) by mouth every 4 hours as needed for cough," but lacked the order for Robitussin 10 ml every 4 hours prn (as needed). The administration section for this medication was blank and lacked documentation this medication was ever administered.

8/17/17 at 2:59 p.m. facility NN by Operator/licensed nurse A "..no more complaint of pain or discomfort related to fall, followed up with hospice, will continue to have staff observe and report to nurse and [any] further complaints."

Documentation lacked assessment of resident's respiratory status and ongoing assessment.

8/18/17 hospice SNVN documented in 9:50 (9:50am) out 10:30 (10:30am) "patient found in activity room not wearing oxygen, SOA (short of air), and O2 (oxygen) sat 80%. Patient immediately put on oxygen at 2L but eventually had to be titrated up to 4L. Staff educated to ensure that patient has oxygen continuously and order written to reinforce this... mottling noted to left foot"

Medical record contained a fax physician's order, dated 8/18/17 by the hospice nurse and APRN: "Patient to be on 4L continuously [continuously underlined] per NC (nasal cannula) of O2."

August 2017 MAR contained an oxygen order, start date 8/18/17, 2L at "12:00pm" - the administration section of this order was blank and lacked documentation the oxygen was ever administered. The vital sign section of MAR

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contained a space for "pulseox" (non-invasive measurement of the oxygen in a person's blood) which remained blank. The MAR and the medical record lacked monitoring of #6's oxygen level while using oxygen and receiving breathing treatments.

8/18/17 facility NN at 2:59 p.m. by facility nurse #F: "8/18/17 1400 (2:00 p.m) this nurse informed hospice nurse that resident's cough and SOA does not seem to be improving. Nurse obtained order for continues O2 at 2L via NC to help with SOA. . . "

Note: order received on 8/18/17 a.m. by hospice documented oxygen 4L to be administered continuously. The record lacked documentation the order for oxygen at 4L continuous was implemented.

8/19/17 facility NN at 10:59 p.m. by facility nurse #F "8-19-17 1333 (1:33 p.m.) resident is refusing to keep O2 on. Resident believes the O2 is a vacuum and will pull it off of his/her face as soon as applied. Floor staff and nursing staff will continue to encourage use of O2.

8/20/17 facility NN at 2:59 p.m. by facility nurse #F: "8/20/17 1600 (4 p.m.) resident continues with dry cough. . . Resident continues to refuse oxygen use at time and other times complies."

The NSA/HSP lacked interventions to address strategies to address oxygen refusal.

8/21/17 hospice SNVN documented in 8:50 (8:50 a.m.) out 9:15 (9:15 a.m.) "patient seen today. Not wearing oxygen nor was concentrator in the common room where the patient was sitting... asked facility nurse #F if he/she would put oxygen

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back on, verbalized understanding... despite this, patient appears to be doing better and coughing less. Mottling still noted to left foot, toes."

8/24/17 hospice SNVN documented in 10:25 (10:25 a.m.) out 10:45 (10:45 a.m.) "patient seen in common room. Patient on room air at this time, staff encouraged to apply 2L per NC continuously. Has had an increase in anxiety... APRN ordered scheduled dose of Ativan in the morning."

8/24/17 at 10:59 p.m. by facility nurse #F: "8/24/17 at 0900 (9 a.m.) resident continues with dry cough, wheezing still present although breathing treatments offer some relief. Resident has been more anxious lately, possibly due to SOA. Hospice nurse obtained order for scheduled Ativan 0.5 mg PO (by mouth) every day. Floor staff will continue to observe and report any changes to the nurse. Resident continues to refuse O2 use at time and other times complies." Note: August MAR lacks documentation breathing treatment administered.

Documentation 9/1/17 through 9/25/17 by facility staff and hospice report continued cough and shortness of air and periodic refusal of oxygen. September 2017 MAR lacked documentation of oxygen administration, lacked documentation of administration of breathing treatments, and lacked documentation of administration of expectorant. Resident #6 health care service plan lacked interventions for staff to follow to encourage oxygen use and monitoring of respiratory symptoms that should be reported to the nurse.

9/26/17 Medical Provider Visit Note (MPVN) by APRN #B at 11:15 a.m. "seen today at facility at request of staff for cough that he/she has had for

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over a week now... has been getting breathing treatments PRN but continues to cough frequently during the day... has PRN cough syrup as well... does get agitated and anxious afternoons and evenings... getting routine Ativan... not eating or drinking very well according to staff reports. PLAN: Acute Bronchitis - schedule Duoneb TID x 3 days and then prn, Prednisone (medication to treat inflammation) 10mg daily with food x 5 days... continue daily Ativan."

9/26/17 Medical record contained a written order signed by APRN #B:
"Duoneb breathing tx (treatment) TID (three times daily) for 3 days and then every 4 hours PRN for cough, wheeze;
Prednisone 10mg po daily for 5 days with food for cough, inflammation."

September 2017 MAR documented the following related to these orders:
- Duoneb listed on the MAR with 4 separate entries that reflect medication administered on 9/28/17 at 8 a.m. and 12 p.m. and a 3:22 p.m. dose documented as "not completed". No other treatments were recorded on the September 2017 MAR
1. Duoneb 0.5/3.0 inhale 1 vial per nebulizer three times a day times 3 days with start and stop date of 9/28/17; scheduled at 8:00am and 12:00pm; recorded as given at 8:00am and 12:00pm on 9/28/17. No record of further doses given.
2. Duoneb 0.5/3.0 inhale 1 vial per nebulizer three times a day times 3 days with start and stop date of 9/28/17; scheduled "as needed"; dose initialed as given on 9/28/17 and prn log note documented "3:22 p.m. not completed"
The record lacked documentation regarding why

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the treatment was not completed.
3. Duoneb 0.5/3.0 inhale 1 vial per nebulizer three times a day and every 4 hours as needed for cough/shortness of air with start date 8/17/17 and stop date 9/28/17; no doses initialed as given.
4. Duoneb 0.5/3.0 inhale 1 vial per nebulizer every 4 hours as needed for wheezing with a start date of 9/27/17 and stop date of 9/29/17; no doses initialed as given.

- Prednisone 10mg tablet (deltasone 10mg tablet) Take One Tablet by Mouth Every Day Times 5 Days With Food for Cough, Inflammation; with "start date" recorded as 9/27/17, not placed on the MAR until 9/28/17; the MAR and NN lacked reason 9/26/17 order not added until two days later. The administration section for this medication was blank except 9/28/17 when recorded as "not available" and lacked documentation this medication was ever administered.

The Facility NN lacked documentation of the medical provider visit, medication orders, or reason for delay and failure to administer medications. The record lacked documentation of assessment of the resident's ongoing respiratory status and notification of the physician that medications were not administered as ordered.

9/28/17 at 2:59 p.m. facility NN by facility nurse #F recorded "9-28-17-1424 (2:24 p.m.) Resident continues to decline. At this point Resident is refusing to get out of bed due to lethargy and refuses to eat as well as starting to refuse PO (oral) medications. Hospice ordered Robitussin (guaifenesin - an expectorant cough medicine) to which this nurse questioned order. This nurse still believes Pneumonia is possible and a cough

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suppressant doesn't seem like it would help if it is pneumonia. . . . Floor staff and Nursing staff will continue to encourage use of O2."
NOTE: Robitussin is an expectorant cough medication that helps loosen congestion, not a cough suppressant.

9/28/17 Medical record contained a fax physician's order, dated 9/28/17 by the hospice nurse and APRN #B :
"Stop scheduled breathing treatment but keep PRN;
Schedule Roxanol 0.25ml (milliliter) every 4 hours;
Schedule Robitussin every 4 hours 10ml po;
Do Not Feed patient if he/she is coughing/choking/unresponsive;
Keep 2L per NC of O2 on at all times."

September MAR documented the following related to these 9/28/17 orders:
- Duoneb No prn treatments were recorded on the September 2017 MAR after this order date.
- Guaituss syrup (Robitussin) Give 10cc by Mouth Every 4 Hours for Cough at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., 10:00 p.m. with a start date 9/29/17, stop date 10/03/17; The MAR documented the medication was given at 10 p.m. on 9/29/17 and all scheduled doses on 9/30/17.
- Roxanol 0.25ml every four hours at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, 8:00pm; the 4:00pm with a start date of 9/29/17. The MAR documented 6:00pm on 9/29/17 "held per facility nurse #F" but lacked documentation of the reason medication held. The MAR documents the first dose administered at 10:15 p.m. on 9/29/17. Medication documented as given on 9/30/17 at 1:00 a.m., 4:33 a.m. , 7:29a .m., 11:57 a.m., 2:38pm, and 7:14 p.m.; "not completed" with no

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explanation at 4:53pm, given at 7:14pm.

- Oxygen continuous at 2L via NC to help with SOA at 12:00pm routine with 2nd entry in PRN section of Mar with an identical order both with a start date of 8/17/17. The MAR lacked documentation in either section that oxygen was administered or monitored.

9/30/17 fax physician order "Obtain a stat (now) chest X-ray do(sic) to cough. Call RN (hospice) with report." This order signed by APRN #V.

9/30/17 X-ray report documented "mild patchy air space opacities in both lung bases, left worse than right, concerning for pneumonia. Probable trace left pleural effusion."

10/01/17 hospice SNVN documented "Pt (patient) resting in bed (left side lying) upon arrival, lethargic and moaning. Pt holding O2 tubing in hand, community staff report patient will not leave NC in place. Respirations appear labored, congestion audible, pt experiencing a non-productive, dry cough. Lungs sound very course throughout entire lung field (stridor), cap(capillary) refill is slow, extremities are warm. Pt is afebrile, will not open eyes, continues with nonsensical babble. Pt was to begin Levaquin (antibiotic) on 9/31/17 due to pneumonia. Community CMA (certified medication aide) reports pt becomes combative and will not take meds. This nurse assists CMA to getting pt into a sitting position on the side of the bed, pt unable to sit upright so this nurse is behind pt keeping her in upright position. Every time the CMA attempts to administer medications, pt begins flailing arms, moving head back and forth, and refuses to open mouth After multiple attempts and trying to explain to pt the importance of taking the

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antibiotic, pt still refuses to take meds. Community CMA reports has been able to get the morphine down the pt. This nurse instructed CMA to attempt to administer antibiotic when scheduled, but if pt continues to be combative and refuses then don't force it. This nurse place pt into a supine position in the bed with head of bed at approximately 45 degrees. The pt fought the administration of the NC, so this nurse placed the cannula in the nares and tightened the tubing at the nape of the neck instead of placing it around the ears. Pt left the NC in place, O2 at 88% on 2L so this nurse turned O2 up to 3L/min, O2 maintaining above 90%. This nurse contacted DPOA to report decline. This nurse informed DPOA that pt does have pneumonia but is refusing to take meds at this time. DPOA is ok with pt not taking meds (except comfort meds), does not want staff to force pt to take meds. . .."

Note: the MAR documented Levofloxacin 500mg one tablet every day - scheduled at 8:00am, initialed as given on 10/04/17 and on 10/ 05/17 marked "other", no detail or explanation on PRN sheet for reason marked "other".

10/02/17 at 10:59pm facility NN facility record "10-2-17 0800 (8 a.m.). . . Resident has had a major decline from Friday and is mostly comfort measures only at this point. Floor staff and nursing staff will do all possible to keep resident comfortable."

10/02/17 hospice SNVN documented in 12:30 (12:30 p.m.) out 13:30 (1:30 p.m.) "patient withdrawing from touch and loud noises, unable to get blood pressure due to this. Patient muttering and shaking but unresponsive and minimal verbal sounds that are intelligible. Roxanol increased to every two hours, facility

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nurse #F notified after speaking with APRN #B who confirmed order. DPOA notified of visit and changes."

10/03/17 hospice SNVN documented in 16:03 (4:03 p.m) out 16:33(4:33 p.m.) "Ativan scheduled due to increased agitation. DPOA updated."

10/03/17 fax physician order "Discontinue all PO meds; Morphine 0.25ml every 2 hours scheduled; Scopolamine 2 drops every 6 hours scheduled."

Review of October 2017 MAR documented the following related to the 10/3/17 order:
- Two entries for Morphine 0.25 ml:
1. Morphine concentrate 0.25ml under tongue every 2 hours for shortness of air (SOA) scheduled at even hours. The MAR documents no doses given on 10/3/17; 2 p.m. through 10 p.m. doses given on 10/4/17; all except midnight, 8 a,m. and 6 p.m. doses given on 10/5, all except 8 a.m. doses given on 10/6 and 2a.m. - 6 a.m. doses given on 10/7/17.
2. Morphine concentrate 0.25ml under tongue every 4 hours for SOA Hold if sedated . Documented as given at 12 a.m. on 10/03/17 and 12:00 a.m, 8:00am and 12:00pm on 10/04/17.
- Two entries for Scopolamine 1 mg/ml
1. Scopolamine 1mg/ml liquid place 2 Drops Under the Tongue Every 3 Hours as Needed for Excess Secretions with a start date of 10/4/17.
2. Scopolamine 1mg/ml liquid place 2 drops under the tongue every 6 hours (Note: this order also listed "as needed" and appears on MAR with other PRN medications)
The MAR lacked evidence the scheduled scopolamine ever administered.

10/04/17 hospice SNVN documented time in

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11:35 a.m. out 12:35 p.m. ". . Pt rests in bed but twitching/jerking of muscles noticed. When patient is touched he/she clenches muscles and withdraws. Patient is unresponsive otherwise. DPOA expressed that he/she found pt to be agitated/in pain and verbalized that he/she wanted pt to be kept comfortable. Unable to do MAC (mid arm circumference) measurements or blood pressure due to the stress that it was causing on patient.. . . Staff also verbalized that patient seemed to be uncomfortable whenever they were moving him/her. Both the facility and this agency's staff expressed this. APRN #B called to increase dose of scheduled Roxanol and confirmed order. Facility nurse #F was called and order relayed...#F verbalized that he/she did not think that increase was necessary because he/she had not found patient to be in a lot of pain. #F said he/she would 'call APRN #B and take care of it' . . :"

10/04/17 at 10:59 p.m. facility NN recorded "10-4-17-1600 (4 p.m.) "Resident transferred into Hospice suite to allow family and Resident more privacy." The note documented the discussion with the hospice nurse regarding increasing the pain medication and the facility nurse F's disagreement with the order. The entry lacked assessment of the resident.

The record lacked documentation of ongoing monitoring of resident #6 with the next entry by facility licensed nurse on 10/7/17 recording resident's death. The record documents hospice skilled nursing visits on 10/5/17 from 2 to 3:10 p.m. and 10/6/17 at 10:40 p.m. when contacted by the DPOA for resident #6.

10/07/17 at 12:00pm NN facility record "Hospice came to report to this nurse at 11:40am Resident

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| S3026 | Continued From page 20<br>expired. . . .."<br><br>On 10/25/17 at 5:00pm, facility nurse #F stated confirmed he/she had no other documentation of assessment of Resident and/or intervention besides that in the NN.<br><br>The operator failed to ensure resident #6 was not subjected to neglect when he/she was discovered with cough, wheezing, and oxygen saturation level of 83% during a hospice visit completed on 8/17/17 as result of follow up on a reported fall. The medical record lacked an assessment of this condition prior to this encounter. Hospice staff and APRN developed a treatment plan and orders were issued. The record lacked documentation that the orders for breathing treatments and expectorant were administered as ordered. The record also lacked documentation that the oxygen was administered as ordered, that oxygen saturation was monitored or that the health care service plan was updated to provide interventions for refusal to wear oxygen. The medical care provider diagnosed the resident with acute bronchitis on 9/26/17 and issued additional orders. The record lacked documentation those orders were implement as ordered. The resident was diagnosed with pneumonia on 9/30/17 and died on 10/7/17. The record lacked documentation of ongoing nursing assessment of resident #6's respiratory status and interventions to promote comfort.<br><br>- Review of record revealed #5 admitted to facility 02/12/16 with diagnoses of Alzheimer's, dysphagia, vascular dementia, and slow transit constipation.<br><br>The current functional capacity screen of 02/12/17 recorded #5 required assistance with all | S3026 | | |

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activities of daily living (ADLs), experience impaired short term memory, memory recall and decision making and had difficulty communicating.

The negotiated service agreement and health service plan (NSA/HSP) of 02/12/17 documented services for assistance with all ADLs and documented a mechanical soft diet with regular liquids, "complete assistance" with eating meals. The record contained a 3/22/17 addendum adding hospice services.

The facility Nurses notes (NN) entries on 3/14/17, 3/21/17, 3/24/17, 4/11/17, 5/23/17, 6/13/17, and 6/22/17 all stated "PCP (primary care provider) from [name of company] here for rounds, no new orders or concerns at this time, nursing staff will continue to monitor and floor staff will continue to observe."

6/22/17 at 11:02am by facility nurse #F "DPOA (durable power of attorney) contacted this nurse and hospice regarding concern for untreated pain/anxiety. Resident is very tearful and has begun grinding his/her teeth. Order obtained for routine lorazepam and PRN (as needed) medication for pain management."

Documentation lacked assessment of pain and anxiety and the health care service plan lacked interventions to address the resident's pain and anxiety.

The record lacked additional facility nurses notes until 7/28/17.

7/03/17 hospice SNVN time in 10:50 a.m. time out 11:20 a.m. ". . (Patient) difficult to arouse with verbal stimuli, (patient) begins grinding teeth and

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whimpering as soon as eyes open. . (patient) is a 2 person extensive assist for transfers, unable to bear weight. . Both lower extremities from just above knees down develop purple colored splotches while dangling, feet turn a deep purple/blue. heart rate irregular and difficult to hear upon auscultation, cap (capillary) refill is slow. Breath sounds diminished throughout. Pupils unequal and react unequally to light (right smaller than left and reacts slower), small amount of drainage from right eye."

7/09/17 hospice SNVN time in 14:20 (2:20 p.m.) time out 15:30 (3:30 p.m.) "Call to hospice at approximately 1300 (1 p.m.) from community reporting significant decline in condition and possible aspiration. This nurse arrived at approximately 1420 (2:20 p.m.), DPOA was at bedside. Skin was very ashen upon arrival, both lower extremities cold from knees to toes, eyes closed. DPOA states (patient) had been unresponsive when he/she arrived. During this nurse's assessment, (patient) opened eyes and was following commands, . . .lungs clear, breath sounds diminished, vitals stable. This nurse had a community staff member assist with repositioning (patient) HOB (head of bed) raised to approximately 45 degrees. (patient)'s color began to return to his/her normal, no signs/symptoms of difficulty breathing. . . .This nurse informed community staff to leave (patient) in bed with HOB elevated to 45 degrees. This nurse also instructed community staff to elevate HOB to 90 degrees when (patient) is fed or given fluids to help prevent aspiration.

The record lacked documentation of the possible aspiration and assessment of the resident's condition. The NSA/HSP lacked interventions to address the resident's ongoing risk for aspiration.

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| S3026 | Continued From page 23<br><br>7/10/17 hospice SNVN time in 07:35 a.m. time out 08:15 a.m.- ". . . O2 saturation was mid 80's upon arrival, community staff had (patient) hooked up to empty O2 tank, this nurse placed (patient) back on his/her concentrator and repositioned (patient) in bed. O2 quickly moved up to 98% on 2L/min via NC (nasal cannula) and maintained at that level. . . .. Lungs clear, breath sounds strong in right upper lobe and diminished in remaining lobes. . . ."<br><br>7/12/17 hospice SNVN time in 09:15 a.m. time out 09:35 a.m. "Voice message left by this nurse for DPOA at 0950 (9:50 a.m.) regarding (patient)'s diet being changed to pureed and honey thick liquid. Was able to get to talk to him/ her on the phone at 1300 (1 p.m.) to discuss diet change, 100% in agreement with diet change. . ."<br><br>The record lacked documentation that this diet order implemented 7/12/17.<br><br>7/17/17 hospice SNVN time in 08:45 a.m. time out 09:45 a.m. ". . .. recent episode of possible aspiration resulting in diet changed to pureed as necessary and honey thick liquids. (patient) experiencing increased lethargy and drowsiness, staff is to leave (patient) in bed if (patient) is drowsy and lethargic (repositioning per community protocol) (patient) is spending approximately 20-22 hours per day in bed at this time. . ."<br><br>Facility NN on 7/28/17 at 2:59pm by facility nurse #F "Late entry - 7/14/17 0900 (9 a.m.) "Family meeting conducted today with Resident's DPOA and RN (registered nurse) from hospice (#O) Family states they wish for Resident not to be gotten out of bed and to bypass feeding Resident. | S3026 | | |

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| S3026 | Continued From page 24<br>It was explained to the family that withholding meals would not be option but that Resident has a right to refuse the meals when offered. If Resident does not get up for the day he/she will be checked, changed and repositioned every 2 hours. Staff will continue to elevate head of Resident's bed and offer physical assist with feeding. . . .."<br><br>The record contained a fax care provider order form dated by facility nurse on 7/28/17 for "Thick it powder; honey thick liquids" signed by the PCP on 7/31/17. The order lacked diet change to pureed.<br><br>The record continues to lack documentation of the resident change in condition. The NSA/HSP lacked health care services to address resident's diet change, increased lethargy and request for resident to remain in bed.<br><br>The facility NN and hospice SNVN dated 7/19/17 through 8/14 17 documented continued decline. Resident #5 passed away on 8/14/17.<br><br>The operator failed to ensure Resident #5 was not subjected to neglect when he/she experienced a significant decline in condition and possible aspiration on 7/9/17, the licensed nurse failed to assess the resident, document the incident, conduct follow up assessments and implement interventions to address ongoing risk for aspiration. The licensed nurse further failed to follow up on diet change orders for two weeks.<br><br>For resident #5, #6, and #9, the Operator failed to ensure no Resident was subjected to neglect when the licensed nurse failed to assess and provide or coordinate interventions to address these cognitively impaired residents change in | S3026 | | |

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| S3026 | Continued From page 25<br>condition. These failures place the residents in immediate jeopardy for harm, injury or death.<br><br>The jeopardy was corrected on 11/7/17 when the operator submitted a written plan that included:<br>1. All orders received from all medical care providers or third party vendors (home health, hospice) will be written on [facility] forms and given to the home supervisor for implementation<br>-Process: all orders to go through home supervisor for implementation and documentation. Home supervisor will implement orders during their working hours, all other orders will be handled by nurse on-call. Orders will be implemented within 24 hours of being received; emergent orders will be implemented at the time of the incident. Information at the bottom of the form will be completed by the home supervisor for tracking; once order has been implemented and documented, home supervisor will document implementation by filling out order tracking portion on the order form to ensure implementation, complete appropriate actions to fulfil order, and document order and order outcome in resident electronic medical record. If order is medication change, order will be sent to the pharmacy to be filled, delivered and entered into the electronic MAR; orders received after 3:30 p.m. Monday through Friday and on weekends will be entered into the electronic MAR by the home supervisor or nurse on call. Within 24 hours after sending the order to the pharmacy, the home supervisor or nurse on call will verify the medication is being administered by checking the electronic MAR for administration. At least monthly during resident review home supervisor will review all previously implemented orders to ensure compliance.<br><br>2. Staff are trained at orientation and yearly training updates on signs and symptoms to alert | S3026 | | |

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| S3026 | Continued From page 26<br>the nurse. Care staff will observe residents and report to home supervisor or nurse on call signs and symptoms of change in condition immediately and document any observation in the electronic record by the end of the shift. Home supervisor or on call nurse will use nursing judgement to determine if a nurse needs to come in for assessment. If interventions require a nursing assessment, the home supervisor or nurse on call will perform assessment and obtain any needed orders. Changes in orders will be documented in the resident's electronic medical record and the HSP will be changed as needed. Direct care staff will be notified of changes to care plan through notification system in electronic medical record. If immediate changes are required, home supervisor, nurse on call or designee will notify direct care staff verbally. Home supervisor will contact PCP for further direction and hospice if applicable. Home supervisor or nurse on call will ensure documentation of the change in condition in the medical record includes: assessment of change in condition, actions taken, ongoing assessment/response to actions, and any instructions that were given to care staff regarding the change of care due to change in condition. | S3026 | | |
| S3080 SS=D | 26-41-201 (a) (b) Functional Capacity Screen on Admission<br><br>a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. | S3080 | | |

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| S3080 | Continued From page 27<br>The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department.<br>(b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-201(a)<br><br>The census equalled 27 the sample included five discharged Residents. Based on interviews and reviews of records, for one of five sampled (#6), the Operator failed to ensure designated facility staff completed a functional capacity screen (FCS) that included each element and definition specified by the department.<br><br>Findings included:<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.<br><br>The current functional capacity screen of 4/06/17 assessed #6 in need of physical assistance with bathing, dressing, transfers, mobility; in need of supervision with toileting and eating; unable to perform medication and treatment management; usually understood and usually understands; with falls/unsteadiness, impaired vision, and impaired decision making. The cognition/memory recall section (short term memory, long term memory, memory/recall, decision making) was left blank. | S3080 | | |

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| S3080 | Continued From page 28<br><br>The current negotiated service agreement (NSA) and health service plan (HSP) of 4/06/17 recorded assistance with bathing, dressing, toileting, transfer, mobility; medication/treatment management by facility staff; has fall mat and bed alarm; exhibits sundowning. The HSP section titles "Cognition" contained an "x" for "yes oriented to person or place." The remaining three categories were left blank (short term memory, long term memory, decision making skills). A note to the side recorded "oriented to self only."<br><br>The Operator failed to ensure designated facility staff completed a FCS that included each element and definition specified by the department. | S3080 | | |
| S3085 SS=D | 26-41-202 (a) Negotiated Service Agreement<br><br>(a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information:<br>(1) A description of the services the resident will receive;<br>(2) identification of the provider of each service; and<br>(3) identification of each party responsible for payment if outside resources provide a service. | S3085 | | |

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| S3085 | Continued From page 29<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(a)<br><br>The census equalled 27 the sample included five discharged Residents. Based on reviews of records, for one of five sampled (#6), the Operator failed to ensure the negotiated service agreement (NSA) included a description of service the resident would receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide a service.<br><br>Findings included:<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.<br><br>The current 4/06/17 functional capacity screen recorded #6 required physical assistance with bathing, dressing, transfers, mobility; supervision with toileting and eating; Unable to perform medication and treatment management;<br>And recorded communication as usually understood and usually understands. Current or recent problems included falls/unsteadiness, impaired vision, and impaired decision making. The cognition/memory recall section (short term memory, long term memory, memory/recall, decision making) was left blank.<br><br>The current negotiated service agreement (NSA) of 4/06/17 recorded assistance with bathing, dressing, toileting, transfer, mobility; medication/treatment management by facility | S3085 | | |

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| S3085 | Continued From page 30<br>staff; has fall mat and bed alarm; exhibits sundowning. The NSA included PT/OT services by home health agency.<br><br>Medical record Nurses Notes (NN) 4/28/17 documented the discontinuation of OT and PT (occupational therapy/physical therapy). The NSA lacked revision to indicate these services no longer provided.<br><br>NN, medical provider's orders, and the MAR's (medication administration records) documented the addition of Oxygen for #6 on 8/18/17 at 4L (liters) "continuously" and another order for Oxygen on 9/28/17 at 2L "on at all times."<br><br>The NSA lacked the addition of this service to include the provider of the services and the party responsible for payment.<br><br>For resident #6, the Operator failed to ensure the NSA included a description of service the resident would receive, identification of the provider of each service and identification of each party responsible for payment if outside resources provide a service. | S3085 | | |
| S3092 SS=E | 26-41-202 (d) Negotiated Service Agreement Revisions<br><br>(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;<br>(2) following any significant change in condition, as defined in K.A.R. 26-39-100;<br>(3) at least quarterly, if the resident receives | S3092 | | |

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| S3092 | Continued From page 31<br>assistance with eating from a paid nutrition assistant; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(d)<br><br>The census equalled 27 the sample included five discharged Residents. Based on reviews of records, for two of five sampled (#5 and #6), the Operator failed to ensure the review and if necessary the revision of each negotiated service agreement (NSA) and health service plan (HSP) following any significant change in condition as defined in K.A.R. 26-39-100.<br><br>Findings included:<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.<br><br>The current 4/06/17 functional capacity screen assessed #6:<br>In need of physical assistance with bathing, dressing, transfers, mobility;<br>In need of supervision with toileting and eating;<br>Unable to perform medication and treatment management;<br>Usually understood and usually understands;<br>With falls/unsteadiness, impaired vision, and impaired decision making.<br>The cognition/memory recall section (short term | S3092 | | |

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memory, long term memory, memory/recall, decision making) left blank.

The current negotiated service agreement (NSA) and health service plan (HSP) of 4/06/17 recorded assistance with bathing, dressing, , toileting, transfer, mobility; medication/treatment management by facility staff; has fall mat and bed alarm; exhibits sundowning.
The HSP section titled "Cognition" assessed #6 oriented to person or place."
The HSP section titled "Behaviors" coded Wandering with a "yes" and a note "may wander at night when sundowning."

Medical record Nurses Notes (NN) 4/28/17 documented the discontinuation of OT and PT (occupational therapy/physical therapy). These services through home health not removed from the NSA/HSP.

NN, medical provider's orders, and the MAR's (medication administration records) documented the addition of Oxygen for #6 on 8/18/17 at 4L (liters) "continuously", and another order for Oxygen on 9/28/17 at 2L "on at all times."
The NSA/HSP lacked the addition of this service to include the rate, the times of use, monitoring of the effect of the Oxygen, and interventions to address refusals or reluctance to use the oxygen.

By review of hospice skilled nursing visit notes (SNVN) on at least five visits to facility (8/18/17, 8/21/17, 8/24/17, 9/26/17, and 10/01/17), Resident #6 observed without oxygen as ordered. The record lacked documentation of interventions to address the refusals.

The Operator failed to ensure the review and if necessary revision of #6's NSA following any

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| S3092 | Continued From page 33<br>significant change in condition.<br><br>- Review of record revealed #5 admitted to facility 02/12/16 with diagnoses of Alzheimer's, dysphagia, vascular dementia, and slow transit constipation.<br><br>The current functional capacity screen of 02/12/17 assessed #5:<br>Unable to perform bathing, dressing, toileting, transfer, mobility, medication and treatment management;<br>In need of physical assistance with eating;<br>With bladder incontinence, memory, recall, and decision making impairments, and difficulty communicating.<br><br>The NSA and HSP of 02/12/17 documented floor staff to provide bathing, toileting, dressing, transfers, mobility, medications, treatments; on a mechanical soft diet with regular liquids, "complete assistance" with eating meals.<br>The record contained a 3/22/17 addendum adding hospice services.<br><br>Medical record Nurses Notes (NN) of 7/28/17 described a meeting with family members and hospice nurse. This entry described proposed care changes for Resident #5.<br><br>By review of hospice skilled nursing visit notes (SNVN), on 7/09/17 Resident #5 had experienced a "significant decline in condition and possible aspiration." Staff repositioned #5, elevated HOB (head of bed), and #5's ashen skin color returned to normal. Hospice nurse left instructions with staff to elevate HOB to 90 degrees when pt is fed or given fluids to help prevent aspiration. This event not documented in the facility's medical | S3092 | | |

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| S3092 | Continued From page 34<br>record.<br><br>Hospice SNVN of 7/12/17 and 7/17/17 documented discussion and decision by hospice nurse and DPOA to change diet for Resident #5 to "pureed and honey thick liquid." No evidence in record the facility monitored the visits of the outside provider hospice, and no evidence this diet order implemented 7/12/17 or 7/17/17.<br><br>The record contained a 7/28/17 physician's FAX order: "Thick-it powder; honey thick liquids." This belated order still lacked a pureed diet as noted in hospice notes (with DPOA discussion) on 7/12/17 and 7/17/17. The record lacked documentation to explain delay in obtaining physician's order.<br><br>On 11/01/17 Operator #A stated in an email: "Order was written on the 28th. Order was to have been written by Hospice, was changed in our kitchen, hospice nurse forgot to write the order and asked facility nurse #F to write order. Pureed was over looked but changed in the kitchen. This all transpired after meeting with Hospice, family and facility."<br><br>The record lacked assessment of Resident's response to the diet "changed in the kitchen" and lacked documentation of any discussion or clarification to not implement the diet change order.<br>The NSA and HSP not revised to reflect the diet order change requested by family and hospice on 7/12/17.<br><br>The Operator failed to ensure the review and if necessary revision of #5's NSA following any significant change in condition. | S3092 | | |

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| S3101 | Continued From page 35 | S3101 | | |
| S3101 SS=D | 26-41-202 (h) NSA Signatures<br><br>(h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(h)<br><br>The census equalled 27 the sample included five discharged Residents. Based on interviews and reviews of records, for one of five sampled (#6), the Operator failed to ensure each individual involved in the development of the negotiated service agreement/health service plan (NSA/HSP) signed the agreement.<br><br>Findings included:<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.<br><br>The current functional capacity screen of 4/06/17 assessed #6 in need of physical assistance with bathing, dressing, transfers, mobility; in need of supervision with toileting and eating; unable to perform medication and treatment management; usually understood and usually understands; with falls/unsteadiness, impaired vision, and impaired decision making. The cognition/memory recall section (short term memory, long term memory, memory/recall, decision making) left blank. | S3101 | | |

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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 |
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| S3101 | Continued From page 36<br><br>The current negotiated service agreement (NSA) and health service plan (HSP) of 4/06/17 recorded services to be provided to meet the identified needs of the Resident.<br>This NSA/HSP lacked a signature of the Resident or the Resident's legal representative. The NSA/HSP contained the signature of facility nurse #F on 4/06/17 and signature of the Operator 4/06/17. The NSA contained one handwritten note on top right "sent for signature 4-7-17. The record lacked evidence of any further attempts to obtain the signature of the Resident or the legal Representative.<br><br>- Review of record revealed #9 admitted to facility 7/08/16 with diagnoses of Alzheimer's disease, anxiety disorder, depressive disorder, hypertension, and agitation.<br><br>The current functional capacity screen of 6/14/17 assessed #9 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, and eating; unable to perform medication and treatment management, with cognitive and communication impairments.<br><br>The current negotiated service agreement (NSA) and health service plan (HSP) of 5/02/17 recorded facility to provide services to meet these needs. A 6/14/17 NSA amendment added Hospice services for dementia and anxiety. Both the NSA of 5/02/17 and the amendment of 6/14/17 lacked a signature of Resident or representative until 7/21/17.<br><br>By interview on 10/24/17 at 11:59am facility nurse #F stated we usually document day we do the NSA that we mailed it... I have a medical | S3101 | | |

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| S3101 | Continued From page 37<br>assistant taking over mailing them out...<br><br>The Operator failed to ensure each individual involved in the development of the NSA/HSP for #6 signed the agreement. | S3101 | | |
| S3155 SS=E | 26-41-204 (a) Health Care Services<br><br>. (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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-204 (a)<br><br>The census equalled 27 the sample included five discharged Residents. Based on reviews of records, for two of five sampled (#5 and #6), the Operator failed to ensure the licensed nurse provided or coordinate the provision of necessary health care services to meet the needs of residents.<br><br>Findings included:<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease. | S3155 | | |

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| S3155 | Continued From page 38<br><br>The current 4/06/17 functional capacity screen recorded #6 required physical assistance with bathing, dressing, transfers, mobility; supervision with toileting and eating; Unable to perform medication and treatment management;<br>And recorded communication as usually understood and usually understands. Current or recent problems included falls/unsteadiness, impaired vision, and impaired decision making. The cognition/memory recall section (short term memory, long term memory, memory/recall, decision making) was left blank.<br><br>The current negotiated service agreement (NSA) and health service plan (HSP) of 4/06/17 recorded assistance with bathing, dressing, , toileting, transfer, mobility; medication/treatment management by facility staff; has fall mat and bed alarm; exhibits sundowning.<br><br>The HSP section titled "Cognition" assessed #6 oriented to person or place."<br>The HSP section titled "Behaviors" coded Wandering with a "yes" and a note "may wander at night when sundowning." The HSP lacked interventions to address wandering behavior.<br><br>NN, medical provider's orders, and the MAR's (medication administration records) documented the addition of Oxygen for #6 on 8/18/17 at 4 L (liters) "continuously", and another order for Oxygen on 9/28/17 at 2L "on at all times."<br><br>By review of hospice skilled nursing visit notes (SNVN) on at least five visits to facility (8/18/17, 8/21/17, 8/24/17, 9/26/17, and 10/01/17), Resident #6 observed without oxygen as ordered. | S3155 | | |

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| S3155 | Continued From page 39<br>The HSP lacked description of services for oxygen therapy to include interventions for monitoring the effect of oxygen, interventions to address refusal of oxygen and signs and symptoms that should be reported to the nurse.<br><br>For #6, the operator failed to ensure the licensed nurse provided or coordinately the necessary health care services to meet the resident's needs.<br><br>- Review of record revealed #5 admitted to facility 02/12/16 with diagnoses of Alzheimer's, dysphagia, vascular dementia, and slow transit constipation.<br><br>The current functional capacity screen of 02/12/17 recorded #5 unable to perform bathing, dressing, toileting, transfer, mobility, medication and treatment management; required physical assistance with eating; with bladder incontinence, memory, recall, and decision making impairments, and difficulty communicating.<br><br>The NSA and HSP of 02/12/17 documented floor staff to provide bathing, toileting, dressing, transfers, mobility, medications, treatments; on a mechanical soft diet with regular liquids, "complete assistance" with eating meals. The record contained a 3/22/17 addendum adding hospice services.<br><br>By review of hospice skilled nursing visit notes (SNVN), on 7/09/17 Resident #5 had experienced a "significant decline in condition and possible aspiration" Hospice nurse left instructions with staff to elevate HOB to 90 degrees when patient is fed or given fluids to help prevent aspiration. | S3155 | | |

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| S3155 | Continued From page 40<br><br>Hospice SNVN of 7/12/17 and 7/17/17 documented discussion and decision by hospice nurse and DPOA to change diet for Resident #5 to "pureed and honey thick liquid."<br><br>Medical record Nurses Notes (NN) of 7/28/17 as a late entry for 7/14/17 described a meeting with family members and hospice nurse. This entry described proposed care changes for Resident #5 which included not getting the resident out of bed with checking, changing and repositioning the resident every 2 hours.<br><br>The record contained a 7/28/17 physician's FAX order: "Thick-it powder; honey thick liquids." This order lacked a pureed diet as noted in hospice notes (with DPOA discussion) on 7/12/17 and 7/17/17.<br><br>The HSP lacked interventions to address resident #5 remaining in bed with every 2 hour care, lacked interventions to address #5's aspiration risk and lacked description of diet as ordered.<br><br>For #5, the operator failed to ensure the licensed nurse provided or coordinately the necessary health care services to meet the resident's needs. | S3155 | | |
| S3200 SS=E | 26-41-205 (d) (1-2) Facility Administration of Medications<br><br>(d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s | S3200 | | |

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| S3200 | Continued From page 41<br>recommendations. The administrator or operator shall ensure that all of the following are met:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-204 (a)<br><br>The census equalled 27 the sample included five discharged Residents. Based on reviews of records, for two of five sampled (#5 and #6), the Operator failed to ensure the licensed nurse provided or coordinate the provision of necessary health care services to meet the needs of residents.<br><br>Findings included:<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.<br><br>The current 4/06/17 functional capacity screen recorded #6 required physical assistance with bathing, dressing, transfers, mobility; supervision with toileting and eating; Unable to perform medication and treatment management;<br>And recorded communication as usually understood and usually understands. Current or recent problems included falls/unsteadiness, impaired vision, and impaired | S3200 | | |

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| S3200 | Continued From page 42 | S3200 | | |

decision making. The cognition/memory recall section (short term memory, long term memory, memory/recall, decision making) was left blank.

The current negotiated service agreement (NSA) and health service plan (HSP) of 4/06/17 recorded assistance with bathing, dressing, , toileting, transfer, mobility; medication/treatment management by facility staff; has fall mat and bed alarm; exhibits sundowning.

The HSP section titled "Cognition" assessed #6 oriented to person or place."
The HSP section titled "Behaviors" coded Wandering with a "yes" and a note "may wander at night when sundowning." The HSP lacked interventions to address wandering behavior.

NN, medical provider's orders, and the MAR's (medication administration records) documented the addition of Oxygen for #6 on 8/18/17 at 4L (liters) "continuously", and another order for Oxygen on 9/28/17 at 2L "on at all times."

By review of hospice skilled nursing visit notes (SNVN) on at least five visits to facility (8/18/17, 8/21/17, 8/24/17, 9/26/17, and 10/01/17), Resident #6 observed without oxygen as ordered.

The HSP lacked description of services for oxygen therapy to include interventions for monitoring the effect of oxygen, interventions to address refusal of oxygen and signs and symptoms that should be reported to the nurse.

For #6, the operator failed to ensure the licensed nurse provided or coordinately the necessary health care services to meet the resident's needs.

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| S3200 | Continued From page 43<br><br>- Review of record revealed #5 admitted to facility 02/12/16 with diagnoses of Alzheimer's, dysphagia, vascular dementia, and slow transit constipation.<br><br>The current functional capacity screen of 02/12/17 recorded #5 unable to perform bathing, dressing, toileting, transfer, mobility, medication and treatment management; required physical assistance with eating; with bladder incontinence, memory, recall, and decision making impairments, and difficulty communicating.<br><br>The NSA and HSP of 02/12/17 documented floor staff to provide bathing, toileting, dressing, transfers, mobility, medications, treatments; on a mechanical soft diet with regular liquids, "complete assistance" with eating meals. The record contained a 3/22/17 addendum adding hospice services.<br><br>By review of hospice skilled nursing visit notes (SNVN), on 7/09/17 Resident #5 had experienced a "significant decline in condition and possible aspiration" Hospice nurse left instructions with staff to elevate HOB to 90 degrees when patient is fed or given fluids to help prevent aspiration.<br><br>Hospice SNVN of 7/12/17 and 7/17/17 documented discussion and decision by hospice nurse and DPOA to change diet for Resident #5 to "pureed and honey thick liquid."<br><br>Medical record Nurses Notes (NN) of 7/28/17 as a late entry for 7/14/17 described a meeting with family members and hospice nurse. This entry described proposed care changes for Resident #5 which included not getting the resident out of | S3200 | | |

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| S3200 | Continued From page 44<br>bed with checking, changing and repositioning the resident every 2 hours.<br><br>The record contained a 7/28/17 physician's FAX order: "Thick-it powder; honey thick liquids." This order lacked a pureed diet as noted in hospice notes (with DPOA discussion) on 7/12/17 and 7/17/17.<br><br>The HSP lacked interventions to address resident #5 remaining in bed with every 2 hour care, lacked interventions to address #5's aspiration risk and lacked description of diet as ordered.<br><br>For #5, the operator failed to ensure the licensed nurse provided or coordinately the necessary health care services to meet the resident's needs. | S3200 | | |
| S3216 SS=F | 26-41-205 (i) Disposition of Medication<br><br>(i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation.<br>(1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations:<br>(A) Two licensed nurses; or<br>(B) a licensed nurse and a licensed pharmacist.<br>(2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations:<br>(A) Two licensed nurses;<br>(B) a licensed nurse and a medication aide; | S3216 | | |

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| S3216 | Continued From page 45<br>(C) a licensed nurse and a licensed pharmacist; or<br>(D) a medication aide and a licensed pharmacist.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-205(i)<br><br>The census equalled 27 the sample included five discharged Residents. For all Residents, the Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications in sufficient detail for an accurate reconciliation as evidenced by interviews and reviews of records for two of five sampled (#9 and #5). The licensed nurse failed to destroy medications according to acceptable standards of practice when certified staff were allowed to participate in the destruction of controlled medications.<br><br>Findings included:<br>The roster and closed records identified all current and past Residents as receiving facility management of medications.<br><br>- Review of record revealed #9 admitted to facility 7/08/16 with diagnoses of Alzheimer's disease, anxiety disorder, depressive disorder, hypertension, and agitation.<br><br>The current functional capacity screen of 6/14/17 assessed #9 unable to perform medication and treatment management and current negotiated service agreement and health service plan of 5/02/17 recorded medication/treatment management by facility staff. | S3216 | | |

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| S3216 | Continued From page 46<br><br>Physician's orders and MAR's (medication administration records) recorded administration of medications by staff, including some controlled medications (lorazepam, morphine).<br><br>Review of controlled medication count sheets revealed:<br>-Lorazepam 28 one half tablets received 9/18/17, hand written note "destroyed 9/25/17" (note lacked number of tablets destroyed), signed by facility nurse #F and CMA (certified medication aide) #D.<br><br>-Lorazepam 30 whole tablets received 9/18/17, hand written note "destroyed 9/25/17" (note lacked number of tablets destroyed), signed by facility nurse #F and CMA #D.<br><br>The records show no doses documented taken from these delivered supplies.<br><br>-Lorazepam 30 one half tablets received 8/21/17 hand written note "destroyed 9/25/17" (note lacked number of tablets destroyed), signed by facility nurse #F and CMA #D.<br>This page recorded 4 one half tablets remained after doses administered. All doses of page recorded administered for 0800 scheduled time with exception of final dose administered at 1700 on 9/19/17.<br><br>-Lorazepam 30 one half tablets received 8/21/17 hand written note "destroyed 9/25/17" (note lacked number of tablets destroyed), signed by facility nurse #F and CMA #D.<br>This page also recorded 4 one half tablets remained after doses administered. All doses of page recorded administered for 1700 scheduled time. | S3216 | | |

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| S3216 | Continued From page 47<br><br>A controlled substance record for #9 for Lorazepam 30 one half tablets received on 7/25/17 contained an entry dated 8/16/17 with one dose checked out at 1700 leaving 7 doses remaining. This entry was scratched out on count sheet.<br>The next entry dated 8/17/17 one dose at 1700, with 7 doses remaining. The August 2017 MAR documented the dose of 8/16/17 was administered. The record lacked clarification of the discrepancy in the narcotic count.<br><br>Other lorazepam discrepancies reviewed:<br>7/15/17 - July 2017 MAR recorded 1/2 tablet given at 0800, no dose checked out 7/15/17 at 0800 on controlled substance records (CSR) provided<br>7/06/17 - 0200 on CSR checked out 1/2 tablet, July 2017 MAR recorded whole tablet given at 1:57am - but additional note on MAR entry stated "not completed"<br>7/03/17 - 0115 on CSR checked out 1/2 tablet, July 2017 MAR recorded whole tablet given at 1:26am; wrong dose administered<br>6/26/17 - June 2017 MAR recorded 1/2 tablet given at 0800 and at 1700, no doses checked out 6/26/17 on CSR provided<br>6/05/17 - 2224 on CSR checked out 1/2 tablet, June 2017 MAR lacked an entry medication given at 2224, 1/2 tablet dose checked out did not match MAR order for whole tablet as PRN dose<br>6/02/17 - June 2017 MAR recorded 1/2/ tablet given at 1700, no 1700 dose checked out 6/02/17 on CSR provided<br>6/01/17 - 0420 1/2 tablet checked out, June 2017 MAR recorded whole tablet given at 5:00am; wrong dose administered<br>5/27/17 - May 2017 MAR recorded 1/2 tablet given at 0800 and 1700, no doses checked out | S3216 | | |

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| S3216 | Continued From page 48<br>5/27/17 on CSR provided<br><br>On 10/24/17 at 10:30am, Operator #A reviewed the signatures on CSR's with destroy dates of 9/25/17. Operator #A confirmed the signatures as CMA #D and facility nurse #F. Operator #A further confirmed the failure to specify onthe log how many doses were destroyed and the participation of a CMA and a nurse in the destruction of controlled substances was not consistent with the standard of practice or with facility policy.<br><br>Facility policy titled "Disposal of Medications policy #HS06-008.<br>"7.a. ...Document the disposal on a Narcotic Inventory Sheet, with the date, time, amount and method of disposal noted. Both nurses witnessing the disposal must sign the Narcotic Inventory Sheet."<br><br>- Review of record revealed #5 admitted to facility 02/12/16 with diagnoses of Alzheimer's, dysphagia, vascular dementia, and slow transit constipation.<br><br>The current functional capacity screen of 02/12/17 recorded #5 unable to perform medication and treatment management and current negotiated service agreement and health service plan of 2/12/17 recorded medication/treatment management by facility staff.<br><br>Review of written physician orders at time of admission to facility revealed "02/12/16 Levsin 0.125mg sublingual (under the tongue) every 2 hours PRN (as needed) secretions." | S3216 | | |

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| S3216 | Continued From page 49<br>MAR's of 2016 and 2017 documented one dose administered on 6/17/16, no other doses recorded.<br><br>By interview of pharmacy on 10/24/17 Levsin last ordered/delivered for #5 on 02/12/16 (date of admission to facility); ... would have been sent 02/12/16 in a bubble pack (typically 30 doses) and labeled "expires 02/12/17."<br><br>On 10/26/17 at 1:59pm Operator #A unable to provide medication disposition information for the Levsin, to show destruction date and how many doses destroyed after the medication delivered to facility 02/12/16 expired on 02/12/17.<br><br>The current MARS from November 2016 to August 2017 recorded the order date of Levsin as 7/09/16.<br>The record lacked a physician's order for Levsin on 7/09/16.<br><br>On 10/24/17 at 10:30am Operator #A confirmed we do not have a system to account for all medications that are not controlled, the number destroyed, the date, the reason (expired, discontinued, discharged, etc.)...<br><br>For all residents, Licensed nurses and Medication aides failed to maintain records of receipt and disposition of medications in sufficient detail for an accurate reconciliation and failed to destroy medications according to acceptable standards of practice. | S3216 | | |
| S3250 SS=F | 26-41-105 (a) Resident Records<br><br>a) The administrator or operator of each assisted | S3250 | | |

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| S3250 | Continued From page 50<br>living facility or residential health care facility shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices.<br>(1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident.<br>(2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(a)<br><br>The census equalled 27 the sample included five discharged Residents. Based on observations, interviews, and reviews of records, for all Residents of facility, the Operator failed to ensure the maintenance of a record for each Resident in accordance with accepted professional standards and practices.<br><br>Findings included:<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.<br><br>The current functional capacity screen of 4/06/17 recorded #6 cognitively impaired and in need of physical assistance with all activities of daily | S3250 | | |

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| S3250 | Continued From page 51 | S3250 | | |

living. The current negotiated service agreement and health service plan of 4/06/17 recorded facility staff assistance and hospice support to meet these needs.

The facility Nurses Notes (NN) recorded an entry:

8/15/17 - 2:59pm - by facility nurse #F - "8-17-17 900 a.m. Resident presents with cough and has wheezing throughout lungs bilaterally. This nurse called Hospice out to assess Resident. Hospice nurse obtained orders for Duoneb, Robitussin, and Doxycycline...

This identical entry duplicated, entered twice in the NN. This NN entry electronically dated 8/15/17 at 2:59pm and note described events that occurred two days later.

8/20/17 - 2:59pm - by facility nurse #F - "8-20-17 - 1600 (4 p.m.) Resident continues with dry cough. Approached hospice about a possible Xray..."

This NN entry electronically dated 8/20/17 at 2:59pm and the note described events that occurred at 4:00pm, an hour later.

On 11/08/17 at 12:19pm Surveyor requested information to explain process for logging timed nurses notes in the facility Residents' medical records.

On 11/08/17 Operator #A responded in written statement: "...entries cannot always happen at the time the incident occurs, our electronic charting is set up that we can do a late entry... try hard to enter the exact time within this late entry but do not always as we do not want to enter an incorrect time."

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| S3250 | Continued From page 52<br><br>On 11/08/17 facility nurse #F responded in written statement: "...common that nursing charting happens after the fact...when this happens [electronic recordkeeping system] is set up to be able to do a daily 'late entry'. When you do a late entry [electronic recordkeeping system] only brings up the options of 1st, 2nd, or 3rd shift... [electronic recordkeeping system] stamps the time as either 6:59am...2:59pm...10:59pm.... If the material being charted is an 'after the fact' and stating the time the actual incident happened is necessary, the nurse will then enter an actual time of when the event occurred. This is why you may see an earlier time listed time by [electronic recordkeeping system] than when the actual incident occurred. This option is available on [electronic recordkeeping system] for up to 72 hours after the incident. Because of this feature it is possible to log an entry, by accident/oversight, up to 3 days prior to actual incident or event."<br><br>According to the American Nurses Association (ANA) Standards of Practice, documentation in the record must be factual, accurate, complete, and timely. Computer entries are automatically date-and-time stamped; if the entry refers to earlier events, the time referred to should be noted. When making a late entry. Document the time of the entry (if not electronically time and date stamped) and within the body of the note indicate the date and time of the occurrence to which you are referring.<br><br>According to the standards of practice, the "time" (and electronic time stamp) of the entry should reflect the time the entry is actually recorded. The documentation system should not allow the person entering the information to select a shift of choice up to 72 hours prior to actually making the entry. | S3250 | | |

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| S3258 SS=F | 26-41-105 (e) Electronic Medical Record<br><br>(e) If electronic medical records are used, each administrator or operator shall ensure the development of policies addressing the following requirements:<br>(1) Protection of electronic medical records, including entries by only authorized users;<br>(2) safeguarding of electronic medical records against unauthorized alteration, loss, destruction, and use;<br>(3) prevention of the unauthorized use of electronic signatures;<br>(4) confidentiality of electronic medical records; and<br>(5) preservation of electronic medical records.<br>(f) Each resident record shall contain at least the following:<br>(1) The resident's name;<br>(2) the dates of admission and discharge;<br>(3) the admission agreement and any amendments;<br>(4) the functional capacity screenings;<br>(5) the health care service plan, if applicable;<br>(6) the negotiated service agreement and any revisions;<br>(7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency;<br>(8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition;<br>(9) the name, address, and telephone number of the case manager, if applicable;<br>(10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and | S3258 | | |

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| S3258 | Continued From page 54<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(e)<br><br>The census equalled 27 the sample included five discharged Residents. Based on observations, interviews, and reviews of records, for all Residents of facility, the Operator failed to ensure the development of policies and procedures addressing the use, protection, safeguarding, prevention of unauthorized use and access, confidentiality, preservation, and content of facility electronic medical records.<br><br>Findings included:<br><br>- By observations on 10/18/17, 10/19/17, 10/23/17, 10/24/17, 10/25/17, and 10/26/17, staff utilized electronic medical records for all records of medication administration, nurses notes and direct care staff documentation.<br><br>On 10/30/17 Surveyor requested the facility policies and procedures governing the use of electronic medical records for Residents.<br><br>On 10/30/17 Operator #A responded by email "We do not have a policy/procedure for electronic records."<br><br>The Operator failed to ensure the development of policies and procedures addressing all required aspects governing the use of electronic medical records for Residents of the facility. | S3258 | | |

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| S3261 SS=F | 26-41-105 (f) (11) Resident Record Documentation of Incidents<br><br>(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<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(f)<br><br>The census equalled 27 the sample included five discharged Residents. Based on interviews and reviews of records, for four of five sampled (#5, #6, #9 and #7), the Operator failed to ensure the Resident's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action.<br><br>Findings included:<br><br>- Review of record revealed #9 admitted to facility 7/08/16 with diagnoses of Alzheimer's disease, anxiety disorder, depressive disorder, hypertension, and agitation.<br><br>The current functional capacity screen of 6/14/17 assessed #9 required physical assistance with all activities of daily living (ADL) and had impaired short term memory, long term memory, memory recall and decision making.<br><br>The current negotiated service agreement (NSA) and health service plan (HSP) of 5/02/17 | S3261 | | |

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| S3261 | Continued From page 56 | S3261 | | |

recorded services for all ADLs. The HSP recorded #9 on a "regular diet, feeds self sometimes with cuing but may need assistance to stay on track." A 6/14/17 NSA amendment added Hospice services for dementia and anxiety.

Confidential interviews of multiple employees (#R, #N, #M, #I, #Q, #U, #J, #F) revealed #9 experienced a sudden change in condition 9/19/17 during the facility noon meal. General consensus of interviewees statements reported:
#9 was usual self the night of 9/18/17 and morning of 9/19/17
#9 was being cued and/or fed noon meal, as was usual for him/her,
#9 began coughing and/or choking
#9 was removed from the dining room in his/her wheelchair
#9 continued to cough and expectorate phlegm and mucous during afternoon hours without medical intervention
#9 demonstrated inability to return to baseline
Licensed nurse attendance to #9 occurred at 3:45pm when hospice staff summoned to facility
Hospice staff assessed #9, confirmed distress, initiated Oxygen, observed medications administered,
#9 somewhat calmer with interventions
#9 brought to the dining room for evening meal and medications
#9 experienced another dramatic change in condition
#9 removed from dining room, hospice staff summoned to facility attend to him/her,
#9 expired at 6:14pm

9/19/17 Hospice "Skilled Nursing Visit Note" (SNVN) with time in 15:45 (3:45 p.m.) time out 16:50 (4:50 p.m.) documented "Pulse 126, respirations 22 labored, blood pressure 152/94,

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| S3261 | Continued From page 57<br>oxygen saturation 66% room air; anxiety 10, shortness of breath 7, pain, difficulty swallowing, speech incoherent, rapid, slurred, abnormal; shallow breath sounds at rest, oxygen saturation 90% with oxygen applied; diminished breath sounds LLL(left lower lung lobe), RLL (right lower lung lobes), coarse breath sounds LUL(left upper lung lobe), RUL (right upper lung lobe), RML (right middle lung lobe). Treatment initiated opioids, oxygen, and other medications."<br><br>Hospice Narrative notes by Hospice RN (registered nurse) #E documented: "this nurse called to facility due to patient having increase secretions per med aide. . . in wheelchair, VERY agitated, gasping for air while trying to voice needs... is physically rocking back and forth in chair unable to get settled... pulse oximeter at 66% with noted cyanosis to hands and feet. Oxygen immediately administered via NC (nasal cannula) at 4L (liters). Simple mask not used due to secretions patient was trying to get out of mouth due to inability to swallow. This nurse helped patient clear out mouth with a towel and encouraged patient to wipe out the secretions. Staff (facility) verbalized that patient had choking episode at lunch and "ever since that time had been like this." . . . Facility nurse #F, gotten from back office and again notified of patient's condition by this nurse. Facility nurse #F asked to get Roxanol (medication used for pain and air hunger), and scopolamine (to reduce saliva) from EKIT (emergency kit containing medications ordered by hospice to treat pain, anxiety, nausea, agitation and increased secretions) as well as Ativan (antianxiety) from already standing PRN orders. Roxanol administered. Then approximately 5 minutes later the Ativan and scopolamine were administered. Call placed to APRN and family. After approximately 15 minutes | S3261 | | |

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| S3261 | Continued From page 58<br><br>patient had visibly calmed down and oxygen sat [saturation] had come up. Patient was no longer gasping for air, and eyes were no longer bulging. Patient could still not voice thoughts and was coughing up secretions but there was not any food in mouth that this nurse could see. Facility nurse #F in agreement to schedule EKIT meds. Staff educated on aspiration and precautions. This nurse left patient on 4L O2 per NC (nasal cannula) in wheelchair where he/she was calm and attempting to rest. APRN returned call and verbalized agreement of plan with no new orders noted. Visit date and time confirmed by facility nurse #F with signature captured on 9/19/17 15:58 (3:58 p.m.).<br><br>9/19/17 hospice SNVN with time in 18:00 (6:00 p.m.), time out 20:00 (8:00 p.m.). Narrative notes of visit by Hospice RN #G documented: "Received call from facility CMA (certified medication aide) stating that patient had declined quickly and that a hospice nurse was needed right away. Stated fluid was exiting mouth and skin tone extremely pale. This nurse arrived to patient sitting in living room with oxygen on. Patient took three more breaths before TOD (time of death) noted with no heart tones and lack of respirations at 18:14 (6:14 p.m.). Was on the phone with family member. Voided of copious amounts of fluids from mouth, white and thick in color. Pallor, eyes fixed, cool to tough. Notified APRN. Assisted 2 certified nurse aides with transfer of patient into wheelchair and into bed... postmortem care... notified facility nurse #C."<br><br>In contrast, the facility medical record nurses notes (NN) contained a 9/5/17 note documenting a health care provider visit with no concerns and no new order and 2 additional entries made on 9/19/17: | S3261 | | |

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| S3261 | Continued From page 59<br><br>9/19/17 2:59pm by facility nurse #F: "Resident had episode of syncope (temporary loss of consciousness usually related to low blood pressure) during lunch today. Has not fully aroused since. PCP (primary care physician) and DPOA (durable power of attorney) and hospice notified. Resident was given PRN dose of Ativan (medication for anxiety) for increase respirations and pulse. Nursing staff will continue to monitor and floor staff will observe."<br><br>9/19/17 at 10:59pm by facility nurse #F documents "at 1814 (6:14 p.m.) hospice nurse in with Resident and notified staff that Resident expired. Hospice notified family . . ."<br><br>The facility medical record lacked documentation of basic assessment information to include vital signs, visual and audible signs and symptoms that displayed evidence of distress, progression or resolution of symptoms, and any ongoing monitoring of Resident's condition; documentation of ongoing assessment of symptoms or nursing interventions between noon meal and hospice arrival at 3:45pm; documentation of the medications and oxygen administered to provide relief; documentation of any care instructions provided to staff in the afternoon hours or during the evening meal time; and documentation of any nursing follow-up to interventions or precautionary instructions provided.<br><br>The Operator failed to ensure #9's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action. | S3261 | | |

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| S3261 | Continued From page 60<br><br>- Review of record revealed #6 admitted to facility 4/06/17 with diagnoses of dementia, gastroesophageal reflux disease, atrial fibrillation, hypertension, and chronic kidney disease.<br><br>The current functional capacity screen of 4/06/17 recorded #6 required physical assistance with transfers, mobility and medication and supervision with toileting and eating. The cognition/memory recall section was incomplete.<br><br>The current negotiated service agreement (NSA) and health service plan (HSP) of 4/06/17 recorded facility staff assistance with bathing, dressing, toileting, transfer; and medication/treatment and documented #6 on a "regular diet"<br>A 7/26/17 NSA amendment added Hospice services for weight loss and unexplained episodes of syncope.<br><br>The Nurses Notes (NN) recorded:<br>8/16/17 at 10:59 p.m. by licensed nurse #C : "staff called this nurse to report that resident had a fall. This nurse came to assess. Staff reported that at 2115 (9:15 p.m.) resident's alarm sounded, when staff went to room they found resident just going onto the floor, leaned over and left side of body was against the wall, resident was also yelling for help, upon assessment, resident has skin tear to left side of forehead, skin tear to left hand 5th digit. . . , b/p (blood pressure) 166/58, pulse 64, respirations 26, temp 98.4" The note recorded licensed nurse C applied first aid to the injuries, administered Tylenol for pain and faxed the medical care provider concerning the fall.<br><br>Record lacked documentation of Resident's respiratory status and notification of hospice of | S3261 | | |

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| S3261 | Continued From page 61 | S3261 | | |

the fall.

8/17/17 hospice "Skilled Nursing Visit Note" (SNVN) documented in at 12:39 (12:39 p.m.) out at 13:30 (1:30p.m.) "informed by HHA (home health aide) Resident had a fall last night. This nurse out to assess. No call made to hospice concerning fall when it had occurred the night prior... patient is seen in dining room... in wheelchair... has prominent laceration to left scalp where steri strips applied... bruising to left lateral upper arm and elbow... verbalizes no pain... does not remember fall... vital signs are taken and oxygen saturation is low at 83%... has non-productive cough and appears to be labored in breathing... lung sounds coarse to all fields... asked three staff members for oxygen but no stock oxygen is stored... ordered from supply company... instructed staff (facility nurse #F and several certified staff) to start oxygen at 2L (liters) continuously... stressed importance of notification of any patient changes."

As a result of this assessment, hospice staff obtained orders from APRN on 8/17/17: Duoneb (medication for inhalation treatment to treat cough, wheezing , difficulty breathing and chest tightness) TID (three times daily) scheduled for 5 days and every 4 hours PRN and Robitussin (expectorant to help loosen congestion) 10ml (milliliters) every 4 PRN, Doxycycline (antibiotic) 100mg (milligrams) BID (twice daily) for 5 days.

Facility NN 8/17/17 at 2:59 p.m. "..no more complaint of pain or discomfort related to fall, followed up with hospice, will continue to have staff observe and report to nurse and [any] further complaints."

Facility NN documentation lacked assessment of

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| S3261 | Continued From page 62<br>Resident's respiratory status and ongoing assessment.<br><br>August 2017 MAR (medication administration record) documented Doxycycline administered as ordered, Duoneb and Robitussin not administered as ordered.<br><br>Facility NN documentation lacked reason medications not administered and lacked notification of physician.<br><br>Facility NN of 8/18/17, 8/19/17, 8/20/17, recorded off and on refusals of oxygen, but lacked assessment of Resident's respiratory status including physical assessment of the residents and pulse oximetry readings of oxygen level, description of the specific times oxygen off and oxygen on, and notification of the medical care provider of any symptoms of respiratory change.<br><br>9/1/17 through 9/25/17 notes by facility staff continued cough and shortness of air and periodic refusal of oxygen. The notes continued to lack specific times of oxygen refusal and assessment of the resident.<br><br>9/26/17 Visit by APRN #B at 11:15 a.m. "seen today at facility at request of staff for cough that he/she has had for over a week now" with orders written on 9/26/17 for "Duoneb breathing tx (treatment) TID (three times daily) for 3 days and then every 4 hours PRN for cough, wheeze and Prednisone 10mg po daily for 5 days with food for cough, inflammation."<br><br>September 2017 MAR documented these orders were not administered as ordered.<br><br>The Facility NN lacked documentation of the | S3261 | | |

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| S3261 | Continued From page 63<br>medical provider visit, medication orders, or reason for delay and failure to administer medications. The record lacked documentation of assessment of the resident's ongoing respiratory status and notification of the physician that medications were not administered as ordered.<br><br>9/28/17 orders from APRN #B included "Stop scheduled breathing treatment but keep PRN;<br>Schedule Roxanol 0.25ml (milliliter) every 4 hours;<br>Schedule Robitussin every 4 hours 10ml po;<br>Do Not Feed patient if he/she is coughing/choking/unresponsive;<br>Keep 2L per NC of O2 on at all times."<br><br>September 2017 MAR again documented these medications and treatments not administered as ordered. The record lacked documentation of failure to implement orders and lacked ongoing assessment of the resident's respiratory status.<br>9/30/17 X-ray report documented "mild patchy air space opacities in both lung bases, left worse than right, concerning for pneumonia. Probable trace left pleural effusion."<br><br>Facility NN of 10/02/17 at 10:59pm recorded Resident has had a major decline from Friday and is mostly comfort measures only at this point. The documentation lacked an assessment of Resident.<br><br>Hospice notes of 10/02/17 and 10/03/17 record symptoms of decline, contact with family and physician, and new medication orders to be implemented (10/03 "Discontinue all PO meds; Morphine 0.25ml every 2 hours scheduled; | S3261 | | |

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| S3261 | Continued From page 64<br>Scopolamine 2 drops every 6 hours scheduled.")<br><br>October<br>2017 MAR documented these medications and treatments not administered as ordered, and the record lacked documentation of reasons medications were not administered as ordered and lacked documentation of notification of the medical care provider that medications were not given as ordered.<br><br>The record lacked documentation of ongoing assessment and monitoring of Resident #6 with the next entry by facility licensed nurse on 10/7/17 recording resident's death .<br><br>On 10/25/17 at 5:00pm, facility nurse #F confirmed he/she had no other documentation of assessment of Resident and/or intervention besides that in the NN.<br><br>The Operator failed to ensure #9'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.<br><br>- Review of record revealed #5 admitted to facility 02/12/16 with diagnoses of Alzheimer's, dysphagia, vascular dementia, and slow transit constipation.<br><br>The current functional capacity screen of 02/12/17 recorded #5 required assistance with all activities of daily living (ADLs), experience impaired short term memory, memory recall and decision making and had difficulty communicating. | S3261 | | |

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| S3261 | Continued From page 65<br><br>The negotiated service agreement and health service plan (NSA/HSP) of 02/12/17 documented services for assistance with all ADLs and documented a mechanical soft diet with regular liquids, "complete assistance" with eating meals. The record contained a 3/22/17 addendum adding hospice services.<br><br>The facility Nurses notes (NN) entries on 3/14/17, 3/21/17, 3/24/17, 4/11/17, 5/23/17, 6/13/17, and 6/22/17 all stated "PCP (primary care provider) from [name of company] here for rounds, no new orders or concerns at this time, nursing staff will continue to monitor and floor staff will continue to observe."<br><br>No documentation available for these visits except 3/21/17. On 11/01/17 Operator #A reported #5 not seen on the other dates listed.<br><br>6/22/17 at 11:02am by facility nurse #F "DPOA (durable power of attorney) contacted this nurse and hospice regarding concern for untreated pain/anxiety. Resident is very tearful and has begun grinding his/her teeth. Order obtained for routine lorazepam and PRN (as needed) medication for pain management."<br><br>Documentation lacked assessment of pain and anxiety and lacked follow up assessment to determine if medication was effective.<br><br>The record lacked additional facility nurses notes until 7/28/17.<br><br>Hospice visit notes of 7/09/17 time in 14:20 (2:20 p.m.) time out 15:30 (3:30 p.m.) "Call to hospice at approximately 1300 (1 p.m.) from community | S3261 | | |

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reporting significant decline in condition and possible aspiration. This nurse arrived at approximately 1420 (2:20 p.m.), DPOA was at bedside. Skin was very ashen upon arrival, both lower extremities cold from knees to toes, eyes closed. DPOA states (patient) had been unresponsive when he/she arrived. During this nurse's assessment, (patient) opened eyes and was following commands, . . .lungs clear, breath sounds diminished, vitals stable. This nurse had a community staff member assist with repositioning (patient) HOB (head of bed) raised to approximately 45 degrees. (patient)'s color began to return to his/her normal, no signs/symptoms of difficulty breathing. . . .This nurse informed community staff to leave (patient) in bed with HOB elevated to 45 degrees. This nurse also instructed community staff to elevate HOB to 90 degrees when (patient) is fed or given fluids to help prevent aspiration.

The facility record lacked documentation of the possible aspiration and assessment of the resident's condition or follow up assessment of the resident's condition.

7/12/17 hospice SNVN time in 09:15 a.m. time out 09:35 a.m. "Voice message left by this nurse for DPOA at 0950 (9:50 a.m.) regarding (patient)'s diet being changed to pureed and honey thick liquid. Was able to get to talk to him/her on the phone at 1300 (1 p.m.) to discuss diet change, 100% in agreement with diet change. . ."

The record lacked documentation that this diet order implemented 7/12/17.

The Operator failed to ensure #5's record contained documentation of all incidents,

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| S3261 | Continued From page 67<br>symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action.<br><br>- Review of record revealed #7 admitted to facility 4/22/14 with diagnoses of dementia, psychosis, chronic bilateral subdural hematomas, hypertension, CVA, renal insufficiency, and seizure disorders.<br><br>The current functional capacity screen of 4/22/17 recorded #7 unable to perform all activities of daily living (ADLs), needed physical assistance with eating, experienced impaired short term memory, long term memory, memory recall and decision making and had difficulty communicating.<br><br>The negotiated service agreement and health service plan (NSA/HSP) of 4/22/17 documented services for assistance with all ADLs and documented a mechanical soft diet, "moderate assistance" with eating meals.<br>The Resident received hospice services.<br><br>Nurses notes (NN) of 3/28/17, 4/25/17, 6/14/17, and 6/22/17 record repetitive observations Resident "refuses meals... losing weight... altered level of consciousness... refusing medications.<br><br>The NN lacked documentation of ongoing assessments of Resident, actions taken, and the results of the actions.<br><br>6/22/17 - according to facility NN, comfort care initiated.<br><br>No further documentation in medical record related to monitoring of Resident, ongoing | S3261 | | |

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| S3261 | Continued From page 68<br>assessment, comfort measures provided, contacts with hospice or family.<br><br>The next and final note of record dated 7/21/17 at 2:59pm "LE (late entry) 6/24/17 - Resident expired at approximately 2100 (9 p.m.) after days of refusing meals and meds aside from PRN medications. Hospice and PCP notified. Had trouble reaching family but was finally able to make contact at 2240. Body released to mortuary."<br><br>The Operator failed to ensure #7's record contained documentation of all incidents, symptoms and other indications of illness or injury, including the date, time of occurrence, action taken, and results of the action. | S3261 | | |