| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| FUSION SENIOR CARE HOMES LLC | 512 N BEBE STREET WICHITA, KS 67212 |

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| {S 000} | INITIAL COMMENTS<br><br>The following citations represent the findings of a revisit for correction order #17-71 of the above home plus facility on 8/9/17, 8/10/17, and 8/14/17. | {S 000} | | |
| S5026 SS=J | 26-42-101 (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 26-42-101(f)(1)(B)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observations, and interviews for 1 resident (#1020), owner/operator/licensed nurse B failed to ensure no resident was subjected to neglect when he/she failed to provide and coordinate necessary services to address resident #1020's risk for elopement and wandering into other resident rooms and aggressive behavior toward others. This failure placed resident #1020 and potentially all residents, in immediate jeopardy for harm, injury, or death.<br><br>Findings included: | S5026 | | |

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

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- Record review for resident #1020 revealed an admission date of 7/28/17 and diagnoses of Alzheimer's disease and agitation.

Functional capacity screen dated 7/29/17 indicated resident was independent with transferring, required supervision with ambulation, experienced impaired long-term memory, communication rarely or never understandable, and resident sometimes understood communication. Current or recent problems included wandering behavior, socially inappropriate disruptive behaviors, and experienced impaired decision-making ability.

Negotiated service agreement/health care service plan dated 7/28/17 documented behavior management of "Receives antianxiety medications." and only service to address resident's wandering behavior as "Need to engage dead-bolt on front door." (Note: operator informed that dead bolt could not be used on door designated as emergency exit; door had to have only 1 locking device that released with the operation of the inside door handle.)

Resident's record contained documentation from resident's emergency department evaluation on 7/28/17 with altered mental state, dementia and combativeness. Medical care provider documented resident's spouse no longer felt safe with resident at home due to resident's combativeness and spouse requested resident to be placed in a facility.

Record contained documentation by licensed nurse F that resident was admitted to the facility around 8:15 p.m. on 7/28/17 and included an order for Ativan (antianxiety medication) 0.5 milligram 1 tablet by mouth every 4 hours as

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| S5026 | Continued From page 2 | S5026 | | |

needed for anxiety.

On 7/29/17, licensed nurse F documented resident continued to be anxious and agitated while going room to room in the facility and resident's antianxiety medication was helpful.

On 7/30/17, certified staff G documented that after supper (resident #1020) hit certified staff G when he/she tried to prevent resident from reaching into the oven. Certified staff G documented resident then headed to room of (resident #1040). Certified staff G documented "(resident #1040) asked (resident #1020) not to go there because that was (resident #1040's) room but suddenly (resident #1020) hit. I immediately asked (resident #1040) to move and helped (him/her) to get away from (resident #1020)." Certified staff G documented he/she notified (licensed nurse F) who came to the facility. Prior to nurse's arrival, resident was throwing things and cursing. Certified staff G documented resident threw away the antianxiety medication he/she gave resident.

On 7/30/17 licensed nurse F documented he/she came to facility at 7:30 p.m. and found resident agitated, pacing, and talking loudly and aggressively. Resident was trying to get out back door. Licensed nurse F got resident to sit down and took about 30 minutes to calm resident. Ativan administered after multiple offers and resident calmer after 15 minutes.

The following documentation obtained from review of aide communication book:

7/28/17 certified staff G documented a new resident (#1020) arrived at the facility for admission.

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| S5026 | Continued From page 3<br><br>8/1/17 at 9:40 a.m. certified staff G documented a police officer came to facility after (resident #1040) called to report (resident #1020) abusing him/her.<br><br>8/1/17 (resident #1020) went into (resident #1040's room) and hit window with his/her shoe. (Resident #1040) "Was scared." After certified staff G assisted (resident #1020) out of room, (resident #1020) attempted to hit certified staff G with his/her shoe.<br><br>8/6/17 certified staff H on second shift documented (resident #1020) going into every room and Ativan did not work so gave (resident #1020) topical Ativan.<br><br>On arrival to the facility at 9:45 a.m. on 8/9/17, surveyor observed commons area open to the front entrance area that included an open kitchen area, dining area, and living area with no physical way to close off the kitchen to residents. Resident #1020 was walking around in the commons area. Surveyor observed resident #1020's behaviors as follows:<br><br>11:00 a.m. resident entered the kitchen and attempted to touch the cooktop of the electric stove where certified staff members were preparing lunch. Certified staff D prevented resident from touching a burner and redirected resident to sit at a dining room table.<br><br>11:15 a.m. resident #1020 got up from the table and walked over to a table where resident #1030 and #1050 were seated. Resident #1020 stood at the table and touched the tablecloth and silverware. Resident #1050 became upset with resident #1020 telling (him/her) to "stop." | S5026 | | |

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Owner/operator/licensed nurse B redirected resident #1020 to sit at another table, asked certified staff D to sit with resident #1020, and told resident #1050 not to talk to (resident #1020) that way. Resident #1050 began complaining to resident #1030 about resident #1020's behaviors. Owner/operator/licensed nurse B instructed resident #1050 to report concerns regarding (resident #1020's) behaviors to staff members and not to other residents.

11:20 a.m. certified staff D went back to kitchen area and resident #1020 got up from table holding a knife and required certified staff to redirect resident.

11:59 a.m. resident #1020 walked to the supply closet by the front entrance, opened and closed the door then walked to the back exit, a sliding glass door. Resident #1020 attempted to turn the lock on the door and tried to open door. Certified staff redirected resident #1020 away from the door.

4:25 p.m. Resident #1020 walked toward resident #1040's room and certified staff D redirected resident. Resident then walked into living area and began pulling items from bookshelf. Certified staff D remained with resident.

During an interview at 1:54 p.m. on 8/9/17, owner/operator/licensed nurse B confirmed the resident's negotiated service agreement/health care service plan lacked interventions to manage resident #1020's behaviors other than use of an antianxiety medication.

At 2:25 p.m. on 8/9/17, certified staff H stated he/she kept resident #1020 with him/her in order

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| S5026 | Continued From page 5 | S5026 | | |

to keep resident from going into other resident rooms. At 4:20 p.m. when asked how he/she monitored resident #1020's whereabouts while providing toileting assistance to resident #1000 and #1060, certified staff H stated he/she asked resident to sit on couch in commons area but resident did not always remain on couch.

At 2:35 p.m. on 8/9/17 resident #1040 confirmed resident #1020 came into his/her room uninvited and moved resident #1040's belongings and threw his/her items away. Resident #1040 stated resident #1020 had not hit him/her but had grabbed his/her wrist.

During an interview at 4:15 p.m. 8/9/17 certified staff D stated today was his/her first day to work in the facility and "I was training with (certified staff C) but because (resident #1020) was anxious and wandering I spent most of day with (resident #1020) to keep other residents from getting upset with (him/her)."

At 4:25 p.m. on 8/9/17, owner/operator/licensed nurse B described staffing pattern of 1 certified employee on duty for each 8 hour shift. Owner/operator/licensed nurse B explained two certified staff members on duty today because certified staff D started today and was training on the 6:00 a.m. to 2:00 p.m. shift and the 2:00 p.m. to 10:00 p.m. shift.

The resident roster included 7 residents and indicated each resident experienced impaired cognition. Residents #1020, #1050, #1070, #1040, and #1030 were independent with mobility. Residents #1060 and #1000 required one-person assistance with mobility in wheelchair and toileting assistance. Each of the 7 residents

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| S5026 | Continued From page 6 | S5026 | | |

required a staff member's assistance to bathe. Surveyor observed the certified staff member on duty was responsible for meal preparation, clean up after the meal, laundry, housekeeping, and medication administration. The one certified staff member on duty would not be able to monitor resident #1020 at all times in order to ensure the safety of all residents. Surveyor observed that each resident would be able to strike back at resident #1020 if provoked by resident #1020.

Owner/operator/licensed nurse B failed to ensure no resident was subjected to neglect when he/she failed to provide and coordinate necessary services to address resident #1020's risk for elopement and wandering into other resident rooms and aggressive behavior toward others. This failure placed resident #1020 and potentially all residents, in immediate jeopardy for harm, injury, or death.

The immediate jeopardy was removed at 8:13 a.m. 8/10/17 when owner/operator/licensed nurse B provided a written plan to provide one to one care to resident #1020 on the first (6:00 a.m. to 2:00 p.m.) shift and second (2:00 p.m. to 10:00 p.m.) shift to facilitate safety and security of (resident #1020).

" This one to one service will include but not limited to the following:

Additional staffing will last up to 30 days in accordance with facility discharge and transfer policy.

Staff will ensure that resident is monitored and at all times in a one to one setting.

Staff will monitor both front and back exits to

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| S5026 | Continued From page 7<br>ensure resident remain in a safe and secure environment at all times.<br><br>Additional staff will facilitate personal care (bathroom breaks, baths etc.).<br><br>Staff will ensure resident is away from the kitchen area as to not accidentally touching a hot surface and may sustain an injury.<br><br>Staff will keep resident from entering into other resident rooms.<br><br>Night shift staff will contact the on-call nurse to assist with resident care if needs be on the night shift since we will only have one staff at night." | S5026 | | |
| S5028 SS=D | 26-42-101 (f) (3) Staff Treatment of Residents Reporting<br><br>(f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met:<br>(A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation.<br>(B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress.<br>(C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator.<br>(D) Appropriate corrective action shall be taken if the alleged violation is verified.<br>(E) The department ' s complaint investigation | S5028 | | |

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| S5028 | Continued From page 8<br>report shall be completed and submitted to the department within five working days of the initial report.<br>(F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-101(f)(3)(A)(B)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observations, and interviews for 1 (#1020) of 3 residents sampled and 1 (#1040) non-sampled resident, owner/operator/licensed nurse B failed to report an allegation of potential abuse and/or neglect to the department within 24 hours of the incident, failed to conduct an investigation in order to rule out abuse and/or neglect, and failed to take immediate measures to prevent further potential abuse and/or neglect.<br><br>Findings included:<br><br>- Record review for resident #1020 revealed an admission date of 7/28/17 and diagnoses of Alzheimer's disease and agitation.<br><br>Functional capacity screen dated 7/29/17 indicated resident was independent with transferring, required supervision with ambulation, experienced impaired long-term memory, communication rarely or never understandable, and resident sometimes understood communication. The functional capacity screen indicated resident exhibited | S5028 | | |

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| S5028 | Continued From page 9 | S5028 | | |

wandering behavior, socially inappropriate disruptive behaviors, and experienced impaired decision-making ability.

Negotiated service agreement/health care service plan dated 7/28/17 documented behavior management of "Receives antianxiety medications." and only service to address resident's wandering behavior as "Need to engage dead-bolt on front door."

Resident's record contained documentation from resident's emergency department evaluation on 7/28/17 with altered mental state, dementia and combativeness. Medical care provider documented resident's spouse no longer felt safe with resident at home due to resident's combativeness and spouse requested resident to be placed in a facility.

Record contained documentation by licensed nurse F that resident was admitted to the facility around 8:15 p.m. on 7/28/17.

On 7/29/17, licensed nurse F documented resident continued to be anxious and agitated while going room to room in the facility and resident's antianxiety medication was helpful.

On 7/30/17, certified staff G documented that after supper (resident #1020) hit certified staff G when he/she tried to prevent resident from reaching into the oven. Certified staff G documented resident then headed to room of (resident #1040). Certified staff G documented "(resident #1040) asked (resident #1020) not to go there because that was (resident #1040's) room but suddenly (resident #1020) hit. I immediately asked (resident #1040) to move and helped (him/her) to get away from (resident

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| S5028 | Continued From page 10 | S5028 | | |

#1020)." Certified staff G documented he/she notified (licensed nurse F) who came to the facility. Prior to nurse's arrival, resident was throwing things and cursing. Certified staff G documented resident threw away the antianxiety medication he/she gave resident.

On 7/30/17 licensed nurse F documented he/she came to facility at 7:30 p.m. and found resident agitated, pacing, and talking loudly and aggressively. Resident was trying to get out back door. Licensed nurse F got resident to sit down and took about 30 minutes to calm resident. Ativan administered after multiple offers and resident calmer after 15 minutes.

The following documentation obtained from review of aide communication book:

7/28/17 certified staff G documented a new resident (#1020) arrived at the facility for admission.

8/1/17 at 9:40 a.m. certified staff G documented a police officer came to facility after (resident #1040) called to report (resident #1020) abusing him/her.

8/1/17 (resident #1020) went into (resident #1040's room) and hit window with his/her shoe. (Resident #1040) "Was scared." After certified staff G assisted (resident #1020) out of room, (resident #1020) attempted to hit certified staff G with his/her shoe.

8/6/17 certified staff H on second shift documented (resident #1020) going into every room and Ativan did not work so gave (resident #1020) topical Ativan.

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| S5028 | Continued From page 11<br><br>Resident's record lacked documentation of immediate measures taken to prevent resident #1020 from entering other resident rooms.<br><br>At 4:25 p.m. on 8/9/17, surveyor observed resident #1020 walk toward resident #1040's room and certified staff D redirected resident.<br><br>At 2:35 p.m. on 8/9/17 resident #1040 confirmed resident #1020 came into his/her room uninvited and moved resident #1040's belongings and threw his/her items away. Resident #1040 stated resident #1020 had not hit him/her but had grabbed his/her wrist.<br><br>During an interview at 1:54 p.m. on 8/9/17, owner/operator/licensed nurse B stated he/she did not report the incident, did not investigate the incident, and did not put interventions into place to keep residents #1020 and #1040 safe.<br><br>Owner/operator/licensed nurse B failed to report an allegation of potential abuse and/or neglect involving residents #1020 and #1040 to the department within 24 hours of the incident, failed to conduct an investigation in order to rule out abuse and/or neglect, and failed to take immediate measures to prevent further potential abuse and/or neglect. | S5028 | | |
| {S5080} SS=E | 26-42-201 (a) (b) Functional Capacity Screen on Admission<br><br>(a) On or before each individual ' s admission to a home plus, 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. | {S5080} | | |

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| {S5080} | Continued From page 12<br>The administrator or operator may integrate the department ' s screening form into a form developed by the home, 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 26-42-201(a)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#1030) of 3 residents sampled , owner/operator/licensed nurse B failed to ensure a licensed nurse completed the functional capacity screen according to each element and definition as specified by the department. Based on record review and interview for 1 (#1020) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure a licensed nurse conducted a screening to determine the individual's functional capacity on or before the resident's admission to the facility.<br><br>Findings included:<br><br>- Record review for resident #1030 revealed an admission date of 11/21/16 and diagnoses of stroke and hypertension. | {S5080} | | |

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| {S5080} | Continued From page 13<br>Functional capacity screen dated 7/22/17 completed by licensed nurse E lacked a score for ability to transfer self.<br><br>Negotiated service agreement dated 11/18/16 documented resident required physical assistance of one person to transfer using a gait belt.<br><br>At 11:30 a.m. on 8/9/17, observed resident walk into the commons area from his/her room independently without a walker. Resident walked to a chair at the dining table and seated self without assistance.<br><br>During an interview at 1:52 p.m. on 8/9/17, owner/operator/licensed nurse B stated resident was independent with transfers. Owner/operator/licensed nurse B confirmed licensed nurse E failed to document on the functional capacity screen resident's ability to transfer self independently.<br><br>Owner/operator/licensed nurse B failed to ensure a licensed nurse completed the functional capacity screen for resident #1030 according to each element and definition as specified by the department.<br><br>- Record review for resident #1020 revealed an admission date of 7/28/17 and diagnoses of Alzheimer ' s disease and agitation.<br><br>The record contained a functional capacity screen dated 7/29/17.<br><br>Record contained documentation by licensed nurse F that resident was admitted to the facility around 8:15 p.m. on 7/28/17. | {S5080} | | |

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| {S5080} | Continued From page 14<br>At 1:54 p.m. on 8/9/17, owner/operator/licensed nurse B stated he/she did not know why a licensed nurse did not conduct a functional capacity screen on admission.<br><br>Owner/operator/licensed nurse B failed to ensure a licensed nurse conducted a screening to determine resident #1020's functional capacity on or before the resident's admission to the facility. | {S5080} | | |
| {S5116} SS=D | 26-42-202 (d) NSA 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:<br>(1) At least once every 365 days;(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 assistance with eating from a paid nutrition assistant; and<br>(4) if requested by the resident or the resident ' s legal representative, 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 26-42-202(d)(2)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#1030) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure the revision of the resident's negotiated service agreement when the | {S5116} | | |

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| {S5116} | Continued From page 15<br>resident experienced a significant change in condition as defined in K.A.R. 26-39-100.<br><br>Findings included:<br><br>- Record review for resident #1030 revealed an admission date of 11/21/16 and diagnoses of stroke and hypertension.<br><br>Functional capacity screen dated 7/22/17 completed by licensed nurse E indicated resident required supervision with mobility and resident used a cane at times. The functional capacity screen lacked a score for ability to transfer self.<br><br>Negotiated service agreement dated 11/18/16 documented resident required physical assistance with mobility utilizing a walker and physical assistance of one person to transfer using a gait belt.<br><br>At 11:30 a.m. on 8/9/17, observed resident walk into the commons area from his/her room independently without a walker. Resident walked to a chair at the dining table and seated self without assistance.<br><br>During an interview at 1:52 p.m. on 8/9/17, owner/operator/licensed nurse B stated resident was independent with transfers and ambulation. Owner/operator/licensed nurse B confirmed licensed nurse E failed to revise the resident's negotiated service agreement.<br><br>Owner/operator/licensed nurse B failed to ensure the revision of resident #1030's negotiated service agreement when the resident experienced a significant change in condition as defined in K.A.R. 26-39-100. | {S5116} | | |

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| {S5155} | Continued From page 16 | {S5155} | | |
| {S5155} SS=E | 26-42-204 (a) Health Care Services<br><br>(a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-204(a)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#1020) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and were in accordance with the functional capacity screening. Based on observation, record review, and interview for 2 (#1000 and #1020) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure a licensed nurse assessed the safety of a bed rail and resident's ability to safely use the bed rail.<br><br>Findings included:<br><br>- Record review for resident #1020 revealed an admission date of 7/28/17 and diagnoses of Alzheimer's disease and agitation. | {S5155} | | |

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| {S5155} | Continued From page 17<br><br>Functional capacity screen dated 7/29/17 indicated resident was independent with transferring, required supervision with ambulation, experienced impaired long-term memory, communication rarely or never understandable, and resident sometimes understood communication. Current or recent problems included wandering behavior, socially inappropriate disruptive behaviors, and experienced impaired decision-making ability.<br><br>Negotiated service agreement/health care service plan dated 7/28/17 documented behavior management of "Receives antianxiety medications." and only service to address resident's wandering behavior as "Need to engage dead-bolt on front door." The negotiated service agreement/health care service plan lacked additional interventions for certified staff members to implement to address resident's wandering behavior, socially inappropriate disruptive behaviors, and impaired decision-making ability.<br><br>Resident's record contained documentation from resident's emergency department evaluation on 7/28/17 with altered mental state, dementia and combativeness. Medical care provider documented resident's spouse no longer felt safe with resident at home due to resident's combativeness and spouse requested resident to be placed in a facility.<br><br>Record contained documentation by licensed nurse F that resident was admitted to the facility around 8:15 p.m. on 7/28/17 and included an order for Ativan (antianxiety medication) 0.5 milligram 1 tablet by mouth every 4 hours as needed for anxiety. | {S5155} | | |

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On 7/29/17, licensed nurse F documented resident continued to be anxious and agitated while going room to room in the facility and resident's antianxiety medication was helpful.

On 7/30/17, certified staff G documented that after supper (resident #1020) hit certified staff G when he/she tried to prevent resident from reaching into the oven. Certified staff G documented resident then headed to room of (resident #1040). Certified staff G documented "(resident #1040) asked (resident #1020) not to go there because that was (resident #1040's) room but suddenly (resident #1020) hit. I immediately asked (resident #1040) to move and helped (him/her) to get away from (resident #1020)." Certified staff G documented he/she notified (licensed nurse F) who came to the facility. Prior to nurse's arrival, resident was throwing things and cursing. Certified staff G documented resident threw away the antianxiety medication he/she gave resident.

On 7/30/17 licensed nurse F documented he/she came to facility at 7:30 p.m. and found resident agitated, pacing, and talking loudly and aggressively. Resident was trying to get out back door. Licensed nurse F got resident to sit down and took about 30 minutes to calm resident. Ativan administered after multiple offers and resident calmer after 15 minutes.

The following documentation obtained from review of aide communication book:

7/28/17 certified staff G documented a new resident (#1020) arrived at the facility for admission.

8/1/17 at 9:40 a.m. certified staff G documented a

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police officer came to facility after (resident #1040) called to report (resident #1020) abusing him/her.

8/1/17 (resident #1020) went into (resident #1040's room) and hit window with his/her shoe. (Resident #1040) "Was scared." After certified staff G assisted (resident #1020) out of room, (resident #1020) attempted to hit certified staff G with his/her shoe.

8/6/17 certified staff H on second shift documented (resident #1020) going into every room and Ativan did not work so gave (resident #1020) topical Ativan.

On arrival to the facility at 9:45 a.m. on 8/9/17, surveyor observed commons area open to the front entrance area that included an open kitchen area, dining area, and living area with no physical way to close off the kitchen to residents. Resident #1020 was walking around in the commons area. Surveyor observed resident #1020's behaviors as follows:

11:00 a.m. resident entered the kitchen and attempted to touch the cooktop of the electric stove where certified staff members were preparing lunch. Certified staff D prevented resident from touching a burner and redirected resident to sit at a dining room table.

11:15 a.m. resident #1020 got up from the table and walked over to a table where resident #1030 and #1050 were seated. Resident #1020 stood at the table and touched the tablecloth and silverware. Resident #1050 became upset with resident #1020 telling (him/her) to "stop." Owner/operator/licensed nurse B redirected resident #1020 to sit at another table, asked

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certified staff D to sit with resident #1020, and told resident #1050 not to talk to (resident #1020) that way. Resident #1050 began complaining to resident #1030 about resident #1020's behaviors. Owner/operator/licensed nurse B instructed resident #1050 to report concerns regarding (resident #1020's) behaviors to staff members and not to other residents.

11:20 a.m. certified staff D went back to kitchen area and resident #1020 got up from table holding a knife and required certified staff to redirect resident.

11:59 a.m. resident #1020 walked to the supply closet by the front entrance, opened and closed the door then walked to the back exit, a sliding glass door. Resident #102 attempted to turn the lock on the door and tried to open door. Certified staff redirected resident #1020 away from the door.

4:25 p.m. Resident #1020 walked toward resident #1040's room and certified staff D redirected resident. Resident then walked into living area and began pulling items from bookshelf. Certified staff D remained with resident.

During an interview at 1:54 p.m. on 8/9/17, owner/operator/licensed nurse B confirmed the resident's negotiated service agreement/health care service plan lacked interventions to manage resident #1020's behaviors other than use of an antianxiety medication.

At 2:25 p.m. on 8/9/17, certified staff H stated he/she kept resident #1020 with him/her in order to keep resident from going into other resident rooms. At 4:20 p.m. when asked how he/she

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monitored resident #1020's whereabouts while providing toileting assistance to resident #1000 and #1060, certified staff H stated he/she asked resident to sit on couch in commons area but resident did not always remain on couch.

At 2:35 p.m. on 8/9/17 resident #1040 confirmed resident #1020 came into his/her room uninvited and moved resident #1040's belongings and threw his/her items away. Resident #1040 stated resident #1020 had not hit him/her but had grabbed his/her wrist.

During an interview at 4:15 p.m. certified staff D stated today was his/her first day to work in the facility and "I was training with (certified staff C) but because (resident #1020) was anxious and wandering I spent most of day with (resident #1020) to keep other residents from getting upset with (him/her)."

Owner/operator/licensed nurse B failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1020 and were in accordance with the functional capacity screening.

- At 9:55 a.m. on 8/9/17, surveyor observed resident #1000 in bed in his/her room with a half bed rail in the raised position on each side of bed.

Record review for resident #1000 revealed an admission date of 11/22/16 and diagnoses of type 2 diabetes mellitus and hypertension.

Functional capacity screen dated 11/22/16 indicated resident required physical assistance with transfers and mobility; was at risk for falls;

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| {S5155} | Continued From page 22<br>and experienced impaired short-term memory, memory recall, and decision-making ability.<br><br>Negotiated service agreement/health care service plan dated 11/22/16 lacked a description of the use and purpose of bed rails.<br><br>Resident's record lacked an assessment by a licensed nurse of the safety of the bed rail and resident's ability to safely use the bed rail.<br><br>At 4:48 p.m. on 8/9/17, owner/operator/licensed nurse B confirmed the lack of an assessment by a licensed nurse of the safety of a bedrail and resident's ability to safely use the bedrail.<br><br>Owner/operator/licensed nurse B failed to ensure a licensed nurse assessed the safety of a bedrail and resident #1000's ability to safely use the bedrail.<br><br>- Record review for resident #1020 revealed an admission date of 7/28/17 and diagnoses of Alzheimer's disease and agitation.<br><br>Functional capacity screen dated 7/29/17 indicated resident was independent with transferring, required supervision with ambulation, and experienced impaired long-term memory. Current or recent problems included wandering behavior, socially inappropriate disruptive behaviors, and experienced impaired decision-making ability.<br><br>At 4:09 p.m. on 8/9/17, surveyor observed a hospital-type bed with a half bed rail in raised position on each side of bed in the resident's room. | {S5155} | | |

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| {S5155} | Continued From page 23<br><br>Resident ' s record lacked an assessment by a licensed nurse of the safety of the bed rails and the resident's ability to safely use the bed rails. Negotiated service agreement/health care service plan dated 7/28/17 lacked a description of the use and purpose of bed rails.<br><br>At 4:09 p.m. on 8/9/17, owner/operator/licensed nurse B confirmed a licensed nurse did not assess the safety of the bed rails and resident's ability to safely use the bed rails.<br><br>Owner/operator/licensed nurse B failed to ensure a licensed nurse assessed the safety of a bedrail and resident #1020's ability to safely use the bedrail. | {S5155} | | |
| {S5300} SS=E | 26-42-205 (d) (1-2) Facility Administration of Medications<br><br>(d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route. | {S5300} | | |

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| {S5300} | Continued From page 24<br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-205(d)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, record review and interview, for 2 (#1000 & #1020) of 3 residents sampled, owner/operator/licensed nurse B failed to ensure certified medication aides administered medications to residents according to standards of practice.<br><br>Findings included:<br><br>- Record review for #1000 revealed an admission date of 11/22/2016 with diagnosis of type 2 diabetes and hypertension.<br><br>Functional capacity screen dated 11/22/2016 indicated resident not able to perform management of medications.<br><br>Negotiated service agreement/Health care service plan dated 11/22/16 stated facility staff will administer medications.<br><br>At 10:05AM on 8/9/2017 surveyor observed the controlled medication sign out sheet for resident #1000's Lorazepam (anti-anxiety medication) 0.5 milligrams (mg) and the controlled medication sign out sheet for resident's Hydrocodone 7.5 mg/Acetaminophen 325 mg (pain medication). Both controlled medication sign out sheets had been initialed by certified staff C, indicating that resident received 1 tablet of each medication at 8:00AM. Both controlled medication sign out sheet for those medications indicated that 28 tablets of each medication remained in each bubble pack. Surveyor noted that there were 29 | {S5300} | | |

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| {S5300} | Continued From page 25 | {S5300} | | |

tablets remaining in each bubble pack. Certified staff C stated he/she signed out for the 2 medications but had not prepared or administered those medications, confirming that he/she did not follow standards of practice of signing out controlled medications at the time of removing medications from the bubble pack.

At 10:05AM on 8/9/17 surveyor observed certified staff C prepare 1 tablet of Lorazepam 0.5mg and 1 tablet of Hydrocodone/AARP 7.5mg/325 mg for resident #1000. He/she handed the prepared medications to certified staff D and instructed him/her to administer the medication. Surveyor observed certified staff C initial the medication record, indicating that he/she had prepared and administered the medications.

Owner/operator/licensed nurse B failed to ensure certified medication aides administered medications to resident #1000 according to standards of practice.

- Record review for resident #1020 revealed an admission date 7/28/17 with diagnosis of Alzheimer's disease and agitation.

Functional capacity screen dated 7/29/17 indicated resident was unable to perform management of medications.

Negotiated service agreement dated 7/28/17 documented certified and licensed staff to administer medications to resident.

August 2017 medication record (MAR) documented resident to receive Lorazepam 0.5mg (anti-anxiety medication) 1 tablet by mouth every 4 hours as needed for anxiety. The MAR contained documentation by certified medication

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| {S5300} | Continued From page 26<br>aides (CMA) that resident received 16 doses between 8/1/17 and 8/8/17. MAR contained documentation by CMA's to explain reason medication was administered for 5 of these doses. The CMA's failed to document the reason for administration for 9 doses. CMA's only documented resident's response for 2 doses of the medication.<br><br>August 2017 MAR documented resident to receive topical Lorazepam 0.5mg every 4 hours as needed.<br>[entry lacked reason for medication to be applied as needed]. The MAR contained documentation by CMA's that resident received 5 doses between 8/2/17 and 8/8/17. MAR contained documentation by CMA's to explain reason medication was administered for 3 doses. CMA's only documented resident's response for 1 dose of the medication.<br><br>At 4:45PM on 8/9/17, owner/operator/licensed nurse B confirmed CMAs did not document medication administration according to standards of practice.<br><br>Owner/operator/licensed nurse B failed to ensure certified medication aides administered medications to residents according to standards of practice. | {S5300} | | |
| S5301 SS=D | 26-42-205 (d) (3) Facility Administration of Medications<br><br>(d) (3) A licensed nurse or medication aide shall perform the following:<br>(A) Administer only the medication that the licensed nurse or medication aide has personally prepared; | S5301 | | |

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| S5301 | Continued From page 27<br><br>(B) identify the resident before medication is administered;<br>(C) remain with the resident until the medication is ingested or applied; and<br>(D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-205(d)(3)(A)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, interview, and record review for 1 (#1000) of 3 residents sampled, certified medication aides failed to administer only the medication that the medication aide personally prepared.<br><br>Findings included:<br><br>- At 10:05AM on 8/9/17 surveyor observed certified staff C prepare 2 medications for resident #1000. Certified staff C handed the prepared medications in a medication cup to certified staff D. Certified staff D carried the medication into the room of resident #1000 and returned, stating (resident) took medications.<br><br>Review of the medication administration record revealed certified staff C initialed that he/she administered the medication. | S5301 | | |

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| S5301 | Continued From page 28<br><br>During an interview at 4:15PM on 8/9/17 certified staff D confirmed he/she administered medications to resident #1000 that he/she did not prepare.<br><br>Certified medication aides failed to administer only the medication that the medication aide personally prepared. | S5301 | | |
| {S5315} SS=E | 26-42-205 (h) Medication Storage<br><br>(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations.<br>(1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.<br>(2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.<br>(3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be | {S5315} | | |

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| {S5315} | Continued From page 29<br>stored by the home.<br>(4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-205(h)(1)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, record review, and interview for all residents, owner/operator/ licensed nurse B failed to ensure all medications were securely and properly stored within a locked medication cart and that only licensed nurses and medication aides had access to the stored medications.<br><br>Findings included:<br><br>- At 9:50 a.m. on 8/9/17, surveyor observed an unlocked closet by the front door of the facility that held 3 bottles of polyethylene glycol powder (laxative) and 1 tube of Icy Hot ointment and 1 tube of Aspercreme.<br><br>At 11:59 a.m. on 8/9/17, surveyor observed resident #1020 open the closet door, look in the closet, and then closed the door. Record review for resident #1020 revealed a diagnosis of Alzheimer's dementia.<br><br>At 12:30 p.m. on 8/9/17, owner/operator/licensed nurse B confirmed the medications were not in a locked medication cart and were accessible to residents and persons unauthorized to administer medications. | {S5315} | | |

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| {S5315} | Continued From page 30<br><br>Owner/operator/ licensed nurse B failed to ensure all medications were securely and properly stored within a locked medication cart and that only licensed nurses and medication aides had access to the stored medications. | {S5315} | | |
| S5345 SS=F | 28-39-437 Building Exterior<br><br>(d) General building exterior.<br><br>(1) Each exterior pathway or access to the facility's common use areas and entrance or exit ways shall meet the following requirements:<br><br>(A) Be made of hard, smooth material;<br><br>(B) be barrier free; and<br><br>(C) be maintained in good repair.<br><br>(2) Outdoor recreation areas shall be provided and available to residents.<br><br>(3) The exterior of the building and the grounds shall be maintained in good repair and in a clean, safe, and orderly manner.<br><br>(4) Each facility house address number shall be posted on the exterior of the facility using at least three-inch-high numbers. Address numbers shall be posted on any mailbox located away from the facility.<br>This REQUIREMENT is not met as evidenced by:<br>KAR 28-39-437(d)(1)(B)<br><br>The facility reported a census of 7 residents. The sample included 3 residents. Based on record | S5345 | | |

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review, observation, and interview for all residents, owner/operator/licensed nurse B failed to ensure all exits from the facility were barrier free.

Findings included:

- Review of the resident roster revealed 7 residents lived in the facility and each resident experienced impaired cognition.

During time spent in the facility on 8/9/17, surveyor observed residents #1050, #1070, #1040, #1020, and #1030 independent with mobility. Resident #1060 and resident #1000 required one-person assistance to mobilize wheelchair.

At 11:59 a.m. on 8/9/17, surveyor observed resident #1020 walk to the back exit, a sliding glass door, and attempted to turn the lock to open the door.

At 3:57 p.m. on 8/9/17, owner/operator/licensed nurse B stated the front entrance door and the sliding glass door at the back of the open commons area were the only exits in the facility. Surveyor observed a dead bolt lock on the interior side of the front exit door. In order to open this door, surveyor had to turn the dead bolt lock and then push down on the door handle. The sliding glass door exit was locked with a mechanism that had to be turned and a piece of wood removed from the door track in order to open the door. Owner/operator/licensed nurse B confirmed each door when locked could not be opened from the inside with one action.

For all residents, owner/operator/licensed nurse B failed to ensure all exits from the facility were

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| S5345 | Continued From page 32<br>barrier free. | S5345 | | |