STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087038	A. BUILDING: _____ B. WING _____	08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DERBY	1709 E WALNUT GROVE DERBY, KS 67037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named facility on 7-31-17, 8-1-17, and 8-2-17.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility identified a census of 23 residents. The sample included 3 residents. Based on record review, interview, and observations for 2 (#111 and #345) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) to address residents' fall risk when the residents' Functional Capacity Screening (FCS) identified both residents experienced impaired cognition. Findings included: - Record review for resident #111 revealed an admit date of 9-15-14 with diagnoses of dementia with behaviors, hypertension, anxiety, chronic	S3155		

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

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S3155	Continued From page 1 pain, glaucoma, and alzheimer's. The annual FCS dated 12-16-16 recorded resident independent with bathing, toileting, transfer, walking/mobility, eating, required physical assistance with dressing, bladder incontinence, experienced short term memory loss, decision making, and falls/unsteadiness. The NSA/HCS dated 12-12-16 recorded resident has arthritis of hands and knees. Resident able to put on and take clothes off with staff attention and independent with grooming. Independent with shower and uses shower chair. Usually continent of bladder and bowel. Independent with toileting. Fall interventions: staff wake resident in morning and family will call later to avoid getting up rapidly, encourage use of low bed, scoop mattress to prompt resident to call for help, fall cushion mat to reduce impact, non slip socks, physical therapy consult, pharmacist to review medications, continue with physical therapy. Resident independent with ambulation and transfers with walker in and out of apartment. Resident to maintain self away from edges of bed. Use bright night lights in bathroom and bedroom or living room to assure light enough to see to when up at night to toilet for safety in case resident turns bathroom light off during night. 12-25-15 Grab bars installed in room for fall prevention. 4-11-16 encourage to open bathroom door open with light on, more checks during night. Resident has short term and decision making impaired with long term memory, memory recall in tact. Staff to provide cues to times and events. The significant change FCS dated 5-15-17 recorded resident was independent with eating,	S3155		

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S3155	Continued From page 2	S3155		

required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, bladder incontinence, experienced short term memory loss, memory recall, long term memory loss, impaired decision making, and falls/unsteadiness.

The NSA/HCS dated 7-19-17 recorded resident has history of depression, arthritis, hospice services for alzheimer's, required physical assistance with dressing, usually continent of bladder, staff to remind resident to use the restroom and provide stand by assistance. Provide stand by assist to and from dining room, be alert to heightened risk for falling, resident has fallen with harm/injury with emergency room (ER) treatment/assessment, resident is independent in his/her apartment using four wheeled walker. Resident to maintain self away from edges of bed, use bright night lights in bathroom and bedroom or living room to assure light enough to see to when up at night to toilet for safety in case resident turns bathroom light off during night. Grab bars installed in room for fall prevention. Encourage to open bathroom door with light on, more checks during night, when resident attempts to be up without walker provide standby assist and set up walker, may use wheelchair when fatigued. Resident has minor word finding problems, short term memory and decision making impaired with long term memory and memory recall all impaired.

The resident log notes recorded the following falls:

2-27-17 at 3:40 p.m. (Licensed nurse A) notified by physical therapist that resident had fallen and gotten self back up. Upon arrival observed resident sitting on sofa. Resident stated was

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S3155	Continued From page 3	S3155		

dizzy and stumbled to knees. Resident denied hitting head and stated not pain. Resident table to move all extremities without pain. Vital Signs (VS) Blood Pressure (B/P) 155/76, Pulse (P) 68, Respirations ® 20, Temperature (T) 98.2. Family notified by Certified Medication Aide (CMA) and physician notified. Interventions: VS times three days and observe for changes in gait, balance, activities of daily living (ADL's), notify nurse on any changes, continue physical therapy, non-slip socks when not wearing shoes. Signed licensed nurse A.

3-31-17 at 2:25 p.m. (Licensed nurse A) notified by staff that resident was on floor in apartment. Nurse immediately went to apartment and observed resident on the floor in living room sitting his/her bottom. Resident denied hitting head and stated no pain. Resident stated was getting up off the sofa to go to the bathroom and knees gave out and fell to the floor. VS B/P 180/80, P 68, R 20, T 97.6. Resident able to move all extremities without pain. Staff assisted resident of the floor and into the bathroom. Physician notified, CMA notified family of fall. Fall interventions: VS times three days, observe for changes in gait/balance/ ADL's, and notify nurse of any changes. Continue physical therapy and encourage use of call light. Signed licensed nurse A.

6-3-17 at 4:15 p.m. (Licensed nurse A) notified that resident was on the floor sitting on his/her bottom sitting between living room and bedroom. VS 150/78, P 78, R 20, T 97.8. Resident denied hitting head and stated no pain. Resident able to move all extremities without pain. Nurse instructed staff to assist resident off the floor. Resident was last seen by staff at 4:00 p.m. when resident was given medication. Physician notified

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and CMA notified responsible party. Interventions: Vital signs times three days, observe for changes in gait, balance, ADL's, and notify nurse if any changes. Continue with physical therapy. Wear non slip socks when not wearing shoes. Visit with physician. Signed licensed nurse A.

6-22-17 at 2:15 p.m. This nurse was in the back sitting area and heard yelling. Certified staff went into resident's room and found resident sitting on his/her bottom by chair in living room. This nurse went to resident apartment and observed resident sitting on floor on bottom by chair. Resident stated no complaints of pain and did not hit head. VS BP 140/90, P 80, R 18, T 95.6. Resident able to move extremities without complaint of pain. Resident assisted off floor into chair. Physician notified. Interventions: vital signs times three days, observed for changes in gait/balance/ADL's and notify nurse of any changes, Encourage resident to stay out in common area during the day, continue physical therapy for transfers. Signed licensed nurse A.

7-6-17 at 7:00 p.m. This nurse was notified by staff that resident was sitting on his/her bottom on the floor in apartment by living room. Resident denied hitting head and no complaints of pain. VS B/P 136/70, P 70, R 20 T 97.7. Resident able to move all extremities without pain. Nurse instructed staff to assist resident off floor and onto sofa. CMA notified responsible party of incident and nurse notified physician. Interventions: vital signs times three days and observe resident for changes in gait/balance/ADL's and notify nurse of any changes, physician appointment next week, prop resident's door open during day to observe resident in apartment.

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S3155	Continued From page 5 7-31-17 at 2:05 p.m. observed certified staff D put gait belt around resident in commons area and take resident to restroom to toilet resident. Certified staff D stated resident required one staff assist for toileting and resident unable to walk without physical assist and required the use of a wheelchair. Interview on 7-31-17 at 2:05 p.m. with licensed nurse A stated resident has had increased falls and resident required physical assistance with transfers. Licensed nurse A stated the last two fall interventions in resident care log notes not in the NSA/HCS plan. 7-31-17 at 3:40 p.m. observed resident in chair in commons area. Resident attempted to get up out of chair two times. No staff in area at this time. Resident #403 sitting next to resident #111 yelled for someone to come and help resident #111 before he/she fell. Certified staff H arrived and assisted resident to sit back in chair. Resident #403 stated he/she yelled for help because resident would fall and he/she could not stand to watch that. Certified staff I sit beside resident to keep him/her from getting up by self. Cognitive impaired resident #111 experienced 5 unwitnessed falls. The HCS lacked appropriate interventions for resident who experienced impaired cognition. - Record review for resident #345 revealed an admit date of 12-1-14 with diagnoses of dementia, Parkinson's, macular degeneration, gastric esophageal reflux disorder and frequent urinary tract infections. The annual FCS dated 7-7-16 recorded resident	S3155		

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independent with dressing, toileting, walking/mobility, required physical assistance with eating, bathing, experienced short term memory loss, decision making and experienced falls/unsteadiness.

The annual NSA/HCS dated 7-7-16 recorded resident has chronic back pain and arthritis, independent with eating, encourage use of night lights, wear properly fitting clothing/shoes, encourage use of grab bars in bathroom, physical therapy, low bed, fall cushion mat to reduce impact if at risk for falls, independent with walker, transfers, ambulation throughout community per resident's request. Staff to provide and set up walker when resident not using walker. Resident tends to furniture walk. 11-3-16 fall vital signs times three days, encourage use of call system, continue physical therapy. 11-18-16 fall, vital signs times three days, physical therapy evaluation, encourage to use call system, grab bars by bath room.

The FCS dated 6-29-17 recorded resident independent with toileting, transfer, walking/mobility, required physical assistance with bathing, dressing, eating, bladder incontinence experienced short term memory loss, impaired decision making, and falls/unsteadiness.

The NSA/HCS dated 6-29-17 recorded staff to assist with dressing and changing brief in morning and evening. Staff assist with shower, independent with all aspects of toileting, wears pull on briefs. Resident has fallen with harm/injury with outside treatment. Fall interventions included use grab bars in bathroom, a night light, wear properly fitting clothing and shoes, encourage use of call system for

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assistance, continue physical therapy, cushion mat to reduce impact of at risk for falls. Resident has short term memory loss and impaired decision making with long term memory in tact. Staff to provide cues to events and times.

Resident log notes recorded the following falls:

11-3-16 at 7:00 p.m. Licensed nurse A notified that resident was on the floor in the bathroom sitting on bottom. Resident stated was trying to clean urine off floor, lost balance and on the way down grabbed the shower curtain. Resident denied hitting head. VS B/P 106/60, P 70, R 20, T 96.0. Resident able to move all extremities without pain. Nurse instructed staff to assist resident up off floor and into bed. Responsible party and physician notified. Interventions: vital signs times three days and observe, antibiotic for urinary tract infection, encourage use of call system for assistance, continue physical therapy for transfers and balance. Signed licensed nurse A.

11-8-17 at 7:30 p.m. Licensed nurse A notified by staff that resident pulled call cord and when staff went in to resident room noted resident was lying in bed. Resident stated he/she had fallen earlier coming out of bathroom. Resident denied hitting head, got up and got into bed. VS B/P 126/74, P 72, R 20, T 97.2. Nurse, family and physician notified. Interventions: vital signs times three days and observe, physical therapy to re-evaluate, look at installing grab bars, encourage use of call system for assistance. Signed licensed nurse A.

3-21-17 at 8:00 a.m. Licensed nurse A was notified by staff that resident stated had a fall in apartment before breakfast. Resident stated got

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up off floor by self and has an abrasion above right eye, forehead, and nose. VS B/P 118/74, P 84, R 20, T 97.7. Nurse encouraged resident to use call system for assistance and not to get up without assistance from staff. Nurse notified responsible party and physician. Appointment made with physician for increased falls on 3-22-17. Interventions: Vital signs times three days, observe for changes in gait/balance/ADL's and notify nurse of any changes. Visit to physician for evaluation, physical therapy to evaluate resident for services with gait and balance. Signed licensed nurse A.

7-6-17 at 4:00 p.m. Licensed nurse A notified by resident that he/she had fallen in room and assisted self up, came out to nursing station to notify nurse. VS taken and observed a scrape on back of spine area approximately "3 by 1". Resident denied hitting head. Resident stated lost balance and fell, got up by self, walked to nurses station to inform staff of fall. Physician notified. Interventions: vital signs times three days, continue with physical therapy, observed for changes in gait/balance/ADL's, notify nurse of any changes, encourage use of call system for assistance. Signed licensed nurse A.

7-30-17 at 8:40 a.m. at approximately 8:40 a.m. certified staff J received call from resident. Upon entering room observed resident standing up by chair in the living room area. Walker was lying sideways on floor. Resident wearing shoes and socks. Noted marks to resident 's face described by certified staff J as rug burn to nose and under eye, goose egg above right eye. Resident stated caught toe on carpet and slid across the floor. Certified staff J called for certified staff K's assistance. VS B/P 132/68, P 84, R 20, T 97.6. Licensed nurse A notified. Family notified.

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Family transported resident to emergency room for evaluation at approximately 9:05 a.m. Resident returned from ER with diagnoses of hematoma and orders for bacitracin three times a day topically to face. Signed licensed nurse B.

Interview on 7-31-17 at 4:45 p.m. with resident stated fell yesterday. Observed large hematoma above right eye and eye swollen shut. Resident's forehead, nose, cheeks, and both eyes bruised. Resident stated had not been able to see out of right eye due to swelling. Resident further stated he/she stood up out of chair, fell and slid across carpet. No other bruising noted. Noted resident having difficult time getting out of rocker chair he/she sat in. Both chairs in living are rocker chairs. Resident confused during interview and referred to "them" pointing to bedroom area as if people was in the bedroom area. Resident also stated was hungry and wanted to get ready for dinner. Then stated he/she was not going to dinner because he/she was not hungry. Resident stated and walked into bathroom without walker and pulled call cord if he/she wanted to get someone to come to room. Licensed nurse A came to room. Resident was very anxious and did not want to leave room.

Interview on 7-31-17 at 5:00 p.m. with licensed nurse A stated had not had time to complete paper work from fall on 7-30-17 and stated was going to meet with operator and family to implement interventions. Resident is confused at times but is concerned he/she may have to leave.

Interview on 7-31-17 with certified staff I stated resident ambulated independently with walker.

For cognitively impaired resident #345, the operator failed to ensure appropriate

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S3155	Continued From page 10 interventions implemented by licensed nurse. For residents #111 and #345, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary HCS to address residents' fall risk when the residents' FCS ididentifed both residents experienced impaired cognition.	S3155		
S3215 SS=E	26-41-205 (h) Medication Storage (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. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility 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. (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. (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	S3215		

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S3215	Continued From page 11 stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)(4) The facility identified a census of 23 residents. The sample included 3 residents and 3 non sampled residents. Based on record review, interviews, and observations for 3 (#400, #401, #402) of 3 non sampled residents, the licensed nurses and certified medication aides (CMA)'s failed to ensure all medications were stored in accordance with manufacturer's recommendations and those of the pharmacy provider. Findings included: - On 7-31-17 at 10:15 a.m. licensed nurse A provided a resident roster that identified facility staff managed and administered medications for residents #400, #401, and #402. Observation of medication cart on 7-31-17 at 11:15 a.m. with CMA D revealed the following narcotics in labeled blister packs with expiration dates between 7-21-16 and 6-30-17: Resident #400, lorazepam .25 Milligrams (MG) (for anxiety) every six hours as needed. The blister pack contained 29 of 30 tablets and expired on 6-30-17. One of two blister packs contained Hydrocodone/acetaminophen 5	S3215		

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S3215	Continued From page 12 MG-325 MG (for pain) one every four hours as needed. The blister pack contained 30 of 30 filled tablets and expired on 7-31-16. Two of two blister packs contained 30of 30 filled tablets of hydrocodone/acetaminophen 5 MG-325 MG and expired on 7-21-16. Resident #401, tramadol 50 MG one tablet every twelve hours as needed for pain. The blister pack contained 11 of 30 filled tablets. Review of Resident #401's current medication orders dated 7-1-17 included order for this medication. Resident #402, acetaminophen 300 MG/codeine 30 MG every six hours as needed for pain. The blister pack contained 30 of 30 filled tablets and expired on 2-28-17. Review of Resident #402's current medication orders dated 7-1-17 included an order for this medication. On 7-31-17 at 11:20 a.m. CMA D and licensed nurse A stated and confirmed the five blister packs with narcotics had expired. Licensed nurse A further stated the night shift nurse is supposed to check medications for expiration dates, and residents (#400, #401, and #402) had orders for medications. For residents #400, #401, and #402, the licensed nurses and certified medication aides (CMA)'s failed to ensure all medications were stored in accordance with manufacturer's recommendations and those of the pharmacy provider.	S3215		