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COMFORT CARE HOMES INC #441	441 S MORNINGSIDE STREET WICHITA, KS 67218

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{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 17-64 of the above home plus facility on 7/3/17, 7/5/17, and 7/6/17.	{S 000}		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#2030) of 3 residents sampled, 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 #2030's elopement risk and when facility staff failed to follow policy and procedure for ensuring doors alarms were on, the gate was locked and the resident was checked frequently. The operator/licensed nurse B further failed to implement appropriate services following resident #2030's second elopement on 6/23/17 when he was found approximately 2 miles from the facility. These failures placed resident #2030 in	S5026		

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

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S5026	Continued From page 1 immediate jeopardy for harm, injury or death. Findings included: - Record review for resident #2030 revealed an admission date of 3/6/17 and diagnoses of Parkinson's disease, dementia, anxiety, depression, and hyperlipidemia. Functional capacity screen dated 3/6/17 indicated resident independent with transferring and walking; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and current or recent problems included wandering and socially inappropriate/disruptive behavior. Negotiated service agreement dated 3/6/17 documented services that included assistance with toileting and ambulation as needed and behavior management and monitoring. Health care service plan dated 3/6/17 included can walk around home without difficulty but tires on long distances and may need a wheelchair for outings; communication: can make wants and needs known and generally understands communication but may have problems processing at times. The health care service plan documented resident was oriented to person and sometimes situation; was at risk for elopement (dated 3/7/17); and exhibited sun downing [a symptom of dementia exhibited by changes in behavior and increased confusion in late afternoon and/or evening]. A licensed nurse documented in the behavior section of the health care service plan resident may get anxious and require (an antianxiety) medication and when exit seeking engage in other activities such as help	S5026		

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set table, clear dishes, work on projects, and offer magazines or books. Health care service plan included a handwritten entry dated 3/7/17 of "Resident has been exit seeking--alarm on back door to patio to alert staff when resident goes outside."; 3/23/17 "Keypad lock placed on back bedroom door east end of home."; 3/23/17 "Frequent checks on resident. " ; and 6/23/17 "15 min (minute) visual check sheet."

Review of resident record and incidents reported to department documented that resident left the facility without staff knowledge (eloped) on 3/23/17 by exiting through a window in an empty resident room and was found approximately 1.5 miles from the facility.

Review of licensed nurse documentation revealed an entry by operator/licensed nurse B at 7:33 p.m. on 6/21/17 as follows:
"Received call from caregiver at 1650 (4:50 p.m.) reporting unable to find resident-arrived at house and second search done-caregiver reported was about 30 minutes since (he/she) last saw resident in living room-notified management staff and search done of surrounding neighborhood-call was placed to 911 at 1714 (5:14 p.m.) and notified-description of resident given-police arrived at home at 1738 (5:38 p.m.) reporting they had found resident and another officer was in route to home with resident-reported that someone had called 911 about resident EMS (emergency medical services) had checked on (resident) and left (resident), when they heard the call about resident and went back and found resident in same area-water was given to resident by officer-resident returned to house without incident-resident assessed again by this nurse-no injury noted-voiced being hungry and tired-notified (medical care provider) and

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S5026	Continued From page 3 (resident's family member)." At 1:09 p.m. on 7/3/17, operator/licensed nurse B stated resident left the facility on 6/21/17 and was found by a police officer at the intersection of Woodlawn and Pawnee, approximately 2 miles south of facility. Operator/licensed nurse B stated investigation of the incident determined resident exited the back door of the facility into the fenced backyard and out through the unlocked gate. Video surveillance camera recorded the one certified staff on duty was sitting in the living room with other residents at this time. Operator/licensed nurse B explained that residents had been in the backyard for an activity earlier that afternoon with the alarm on the back door turned off and a staff member did not ensure the alarm was reactivated after the activity. Operator/licensed nurse B stated the gate was unlocked due to a lawn service mowing the back yard earlier in the day and a staff member did not ensure the gate was locked when the lawn service was finished with the yard work. Operator/licensed nurse B confirmed the gate was unlocked during the time residents were having an activity in the backyard. Operator/licensed nurse B stated a policy was implemented after resident's elopement 6/21/17 for staff members to check that the back door alarm activated and the back yard gate locked at each shift change. [Note: No policy in place to ensure back door alarm activated and functioning and backyard gate locked prior to resident's elopement.] Operator/licensed nurse B stated staff members were now performing and initialing 15 minute visual check of the resident. Operator/licensed nurse B stated he/she reviewed the elopement policy and procedure individually with each person working the facility after resident #2030 eloped but did not document	S5026		

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the review.

At 3:09 p.m. activity director H stated the backyard activity was scheduled from 1:00 p.m. to 2:00 p.m. on 6/21/17. Operator/licensed nurse B stated door alarm was likely turned off at 1:00 p.m. and remained silenced. Activity director, when asked why staff members did not notice gate was unlocked during activity, stated gate was not visible from the patio area.

At 1:30 p.m. on 7/3/17, surveyor drove the route resident might have walked on 6/21/17 and observed the facility located on the corner of Morningside Street and Woodlawn a heavily traveled street with a posted speed limit of 35 miles per hour. Intersection of Woodlawn and Pawnee was located 2 miles south of facility and these 2 miles went through business areas. Resident would have had to cross intersections with traffic lights at intersections of Woodlawn and Kellogg off/on ramps (US 400 highway), Woodlawn and Lincoln; and Woodlawn and Harry. Surveyor observed a traffic light at Woodlawn and Pawnee and a posted speed limit of 45 miles per hour on Pawnee. Noted that June 21, 2017 was a Wednesday with a usual increase in traffic in this route during the time resident was out of facility somewhere between 4:20 p.m. and 5:38 p.m. Wunderground.com documents temperature on 6/21/17 from 4 - 6 p.m. at 90-93 degrees Fahrenheit with 10 - 15 mile per hour wind and no precipitation.

At 2:45 p.m. on 7/3/17, surveyor arrived back to the facility and operator/licensed nurse B answered the door with resident #2030 behind him/her. Operator/licensed nurse B had to hold resident back to keep resident from pushing way through and out the door. Operator/licensed

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nurse B sat and did an activity with resident.

At 2:53 p.m. on 7/3/17, two visitors for resident #2030 arrived and took resident to sit and visit on patio. At 4:08 p.m. resident #2030 came into the house and quickly walked to front door with the two visitors following resident. Certified staff D entered key pad code to unlock front door to allow the two visitors to leave. Surveyor observed resident #2030 become angry that he/she could not go out front door. Operator/licensed nurse B took resident out back door to walk in the back yard. Surveyor observed resident walk quickly from one end of yard to the other. At 4:15 p.m. resident came into the facility with operator/licensed nurse B following resident. Operator/licensed nurse B told certified staff D that resident needed medication for anxiety. Resident walked back and forth to front door trying to open door and yelling "Let me out." At 4:20 p.m. resident refused to take an oral medication. Certified staff D followed resident as resident walked up and down halls and into his/her bedroom, another resident's bedroom, and the bathroom trying to open windows. At 4:54 p.m. resident went out back door and operator/licensed nurse B followed resident. Resident and operator/licensed nurse B remained in back yard until 5:15 p.m. and during this time observed that resident tried to climb the wooden privacy fence, tried to climb a wire by the fence, and walked quickly and angrily from one end of yard to the other. Surveyor observed that when resident walked to northeast end of yard where gate located and to northwest end of yard resident could not be viewed from inside the facility. When resident and operator/licensed nurse B came back into the house resident was diaphoretic and appeared exhausted and distraught. Operator/licensed nurse B gave

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resident something to drink and resident threw the liquid out of the glass. Operator/licensed nurse B called resident's medical care provider for an order to repeat administration of topical antianxiety medication. At 5:30 p.m. resident went to table and began eating evening meal.

During time in the facility on 7/3/17, surveyor observed the full standard size windows in room of resident #2030 and #2060, room of resident #2070, and in television room each with a metal screw in place to prevent opening the window. Surveyor observed a key pad lock on the door of resident #2040's room and the door on a resident room on the east end of the facility. Operator/licensed nurse B explained that resident had eloped through the window in the east resident room (3/23/17).

During an interview at 3:19 p.m. on 7/3/17, operator/licensed nurse B stated only one certified staff person on duty at a time on each of the 3 shifts in this facility. Review of the facility's elopement policy and procedure documented the following instruction to staff member on duty:
Make a thorough search of the home, the front yard and the back yard.
Check the yards of the houses on both sides of you.
Notify the nurse manager, on-call nurse, or designee immediately.
Operator/licensed nurse B stated since only one staff member on duty in this house, the staff member could not leave residents alone to go search for the missing resident outside of the house. Operator/licensed nurse B confirmed a search for a resident missing from the facility could not be started until a second person arrived.

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S5026	Continued From page 7 At 2:51 p.m. on 7/3/17, certified staff C confirmed he/she was the only employee on duty in the facility. Certified staff C stated if he/she was in the middle of caring for a resident and saw another resident outside the facility he/she would go out and bring that resident back into the facility. At 3:30 p.m. on 7/3/17, certified staff D stated resident "tries to escape all day, goes to doors and jiggles door handles, and runs to door when the doorbell rings." Certified staff D stated he/she would call 911 if resident left the facility and then call the nurse because he/she cannot leave other residents unattended to go look for the missing resident. At 10:09 a.m. on 7/5/17, certified staff F stated resident goes to doors to check to see if he/she can open doors and this behavior increased after lunch. Certified staff F stated if resident did exit facility on own he/she could not leave other residents alone in house to go look for resident. Resident #2030 was identified as an elopement risk on 3/7/17 as documented by a licensed nurse on the health care service plan. Certified staff members documented resident's on-going exit seeking behaviors in the communication book. Review of documented comments by certified staff members in the communication book revealed the following regarding resident's exit seeking behaviors: 6/2/17 first shift "Got a little wound up earlier trying to get out of here, eventually calmed down." 6/3/17 first shift "Gave Ativan (antianxiety medication) at 10:50 a.m. trying to open back door again." 6/18/17 second shift "Combative, shoving and	S5026		

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hitting staff. Attempting to get out several times. Topical Ativan not effective."
6/19/17 second shift "Tried getting out for a short while."
6/21/17 second shift "Eloped around 4:15 p.m. or so and walked to Pawnee and Woodlawn. Extremely tired."
6/27/17 first shift "Trying to get locks to unlock."
6/27/17 second shift "Agitated after dinner and tried to unlock front door."
6/28/17 second shift "trying to leave all day."
7/3/17 first shift "Calm until about 2:00 p.m."

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 #2030 ' s elopement risk and when facility staff failed to follow policy and procedure for ensuring doors alarms were on, the gate was locked and the resident was checked frequently. The operator/licensed nurse B further failed to implement appropriate services following resident #2030 ' s second elopement on 6/23/17 when he was found approximately 2 miles from the facility. These failures placed resident #2030 in immediate jeopardy for harm, injury or death.

The immediate jeopardy was removed at 5:25 p.m. on 7/3/17, when operator/licensed nurse B provided a written plan to ensure safety of resident #2030 that documented the following: Will have a second caregiver from 7:00 a.m. to 8:00 p.m. during waking hours. Resident sleeps well at night. Will visit with resident's family and will either give a 30 day notice due to unable to meet resident's needs or move to a [sister facility] where there is more staff available. One to one will be until then. Will educate caregivers to provide one to one attention to resident. Night

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S5026	Continued From page 9 staff members will be educated to call nurse if resident with exit seeking tendency and nurse will provide one to one attention to resident. Continue with visual checks, assuring alarms and locks in place.	S5026		
{S5155} SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review, observation, and interview for 2 (#2030 and #2040) of 3 residents sampled, operator/licensed nurse B failed to provide or coordinate the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #2030 revealed an admission date of 3/6/17 and diagnoses of Parkinson's disease, dementia, anxiety,	{S5155}		

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{S5155}	Continued From page 10	{S5155}		

depression, and hyperlipidemia.

Functional capacity screen dated 3/6/17 indicated resident required physical assistance with bathing; supervision with dressing and toileting; independent with transferring, walking; experienced impaired short-term memory, long-term memory, memory recall, and decision making; exhibited wandering behavior and socially inappropriate/disruptive behavior; and did not require an assistive device for mobility.

Negotiated service agreement dated 3/6/17 documented services of bathing assistance and assistance with dressing, toileting, ambulation, and dressing as needed.

Health care service plan dated 3/6/17 included bath aide 2 times a week; will tell staff when needs to go to bathroom; assist with getting clothes out and cue to dress; can walk around home without difficulty but tires on long distances and may need a wheelchair for outings; resident oriented to person and sometimes situation; at risk for elopement (dated 3/7/17); and exhibited sun downing [a symptom of dementia exhibited by changes in behavior and increased confusion in late afternoon and/or evening].

Nurse's notes contained the following entries:

6/8/17 at 12:31 a.m. licensed nurse E documented staff member had just left resident's room where resident was getting undressed for bed. Staff member heard a noise and went back to resident's room and observed resident up and walking with a cut noted to right eye and blood on floor next to bed.

6/11/17 at 7:00 a.m. licensed nurse E

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{S5155}	Continued From page 11 documented staff member called at 6:30 a.m. to report he/she checked on resident and found resident up in room with blood on hands and head. Resident with cut to top right forehead area. 6/11/17 at 7:05 p.m. licensed nurse E documented staff member reported at 1:00 p.m. resident came at him/her with a fork. When staff member turned to back away from resident staff member heard a noise and resident had fallen. No injury identified. 6/14/17 at 7:33 p.m. operator/licensed nurse B documented resident slid off couch on to floor without injury. 6/22/17 at 10:59 a.m. licensed nurse G documented that at approximately 8:30 p.m. resident fell to knees while rearranging dining room chairs. Received skin tear to right forearm. The negotiated service agreement and health care service plan lacked revision to include interventions to address resident's risk for falls. At 10:09 a.m. on 7/5/17, certified staff F stated he/she supervised resident when walking and if resident unsteady with ambulation he/she would stay close to resident. Resident #2030 experienced falls. Operator/licensed nurse B failed to provide or coordinate the provision of necessary health care services that met the needs of resident #2030. - Record review for resident #2040 revealed an admission date of 4/19/11 and diagnoses of cerebral atrophy and osteoporosis.	{S5155}		

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{S5155}	Continued From page 12 Functional capacity screen dated 9/2/16 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility per wheelchair; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls. Negotiated service agreement dated 9/2/16 documented services of bathing assistance 2 times a week and assistance with dressing, toileting, ambulation, and dressing; Negotiated service agreement lacked documentation of services to be provided to address resident's risk for falls as identified on the functional capacity screen. Health care service plan dated 9/2/16 documented physical assistance with all activities of daily living including one-person transfer assistance and to propel wheelchair. Health care service plan lacked interventions to assess resident's risk for falls. At 12:51 p.m. on 7/3/17, operator/licensed nurse B stated resident slid out of wheelchair last evening (7/2/17) and (licensed nurse E) came to facility to assess resident for injuries. During an interview at 9:40 a.m. on 7/5/17, when asked for health care services to address resident's risk for falls operator/licensed nurse B stated resident was not able to get up on own and required physical assistance with all activities of daily living . Operator/licensed nurse B confirmed resident did experience a fall from wheelchair 7/1/17 and stated certified staff member transferred resident to wheelchair from a recliner in the television room in preparation to take resident to bed. Certified staff member left the	{S5155}		

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	B087095	A. BUILDING: _____ B. WING _____	R 07/06/2017

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{S5155}	Continued From page 13 room leaving resident unattended. When certified staff member returned to the room he/she found resident on the floor. On 7/3/17 and 7/5/17 surveyor observed resident in a recliner in the television room and on each day resident had slid down in chair with feet hanging off the foot rest. At 10:17 a.m. on 7/5/17, certified staff F stated intervention to reduce risk for falls as assist resident with everything. Certified staff F stated resident will not stand or walk. Resident #2040 identified as at risk for falls on functional capacity screen. Health care service plan lacked interventions to address resident's risk for falls. Operator/licensed nurse B failed to provide or coordinate the provision of necessary health care services that met the needs of resident #2040 and were in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
{S5251} SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 5 residents. The	{S5251}		

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{S5251}	Continued From page 14	{S5251}		

sample included 3 residents. Based on record review, observation, and interview for 2 (#2030 and #2040) of 3 residents sampled, operator/licensed nurse B failed to ensure each resident record contained documentation of incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.

Findings included:

- Record review for resident #2030 revealed an admission date of 3/6/17 and diagnoses of Parkinson's disease, dementia, anxiety, depression, and hyperlipidemia.

Functional capacity screen dated 3/6/17 indicated resident required physical assistance with bathing; supervision with dressing and toileting; independent with transferring, and walking; experienced impaired short-term memory, long-term memory, memory recall, and decision making; exhibited wandering behavior and socially inappropriate/disruptive behavior; and did not require an assistive device for mobility.

Negotiated service agreement dated 3/6/17 documented services of bathing assistance 2 times a week; assistance with dressing, toileting, ambulation, and dressing as needed; and behavior management and monitoring.

Health care service plan dated 3/6/17 included bath aide 2 times a week; will tell staff when needs to go to bathroom; assist with getting clothes out and cue to dress; can walk around home without difficulty but tires on long distances and may need a wheelchair for outings. The

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{S5251}	Continued From page 15	{S5251}		

health care service plan documented resident was oriented to person and sometimes situation; was at risk for elopement (dated 3/7/17); and exhibited sun downing [a symptom of dementia exhibited by changes in behavior and increased confusion in late afternoon and/or evening]. A licensed nurse documented in the behavior section of the health care service plan resident may get anxious and require (an antianxiety) medication and when exit seeking engage in other activities such as help set table, clear dishes, work on projects, and offer magazines or books. Health care service plan included a handwritten entry dated 3/7/17 of "Resident has been exit seeking--alarm on back door to patio to alert staff when resident goes outside."; 3/23/17 "Keypad lock placed on back bedroom door east end of home."; 3/23/17 "Frequent checks on resident. " ; and 6/23/17 "15 min (minute) visual check sheet."

At 1:09 p.m. on 7/3/17, operator/licensed nurse B stated resident left the facility on 6/21/17 and was found by a police officer at the intersection of Woodlawn and Pawnee,

At 2:53 p.m. on 7/3/17, two visitors for resident #2030 arrived and took resident to sit and visit on patio. At 4:08 p.m. resident #2030 came into the house and quickly walked to front door with the two visitors following resident. Certified staff D entered key pad code to unlock front door to allow the two visitors to leave. Surveyor observed resident #2030 become angry that he/she could not go out front door. Operator/licensed nurse B took resident out back door to walk in the back yard. Surveyor observed resident walk quickly from one end of yard to the other. At 4:15 p.m. resident came into the facility with operator/licensed nurse B following resident.

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{S5251}	Continued From page 16 Operator/licensed nurse B told certified staff D that resident needed medication for anxiety. Resident walked back and forth to front door trying to open door and yelling "Let me out." At 4:20 p.m. resident refused to take an oral medication. Certified staff D followed resident as resident walked up and down halls and into his/her bedroom, another resident's bedroom, and the bathroom trying to open windows. At 4:54 p.m. resident went out back door and operator/licensed nurse B followed resident. Resident and operator/licensed nurse B remained in back yard until 5:15 p.m. and during this time observed that resident tried to climb the wooden privacy fence, tried to climb a wire by the fence, and walked quickly and angrily from one end of yard to the other. When resident and operator/licensed nurse B came back into the house resident was diaphoretic and appeared exhausted and distraught. Operator/licensed nurse B gave resident something to drink and resident threw the liquid out of the glass. Operator/licensed nurse B called resident's medical care provider for an order to repeat administration of topical antianxiety medication. At 5:30 p.m. resident went to table and began eating evening meal. Continued record review on 7/5/17 revealed the lack of documentation by operator/licensed nurse B of the resident's behavior, action taken, and result of the action. Review of the resident's July 2017 medication administration record revealed documentation on 7/3/17 of two sets of the initials of certified staff D that he/she administered 2 doses of topical lorazepam (Ativan an antianxiety medication) 1 milligram (mg) per milliliter (ml) apply 0.5 ml (0.5 mg) every 4 hours if unable to give by mouth. The medication administration record lacked documentation for each dose	{S5251}		

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administered of the time applied, reason applied, and resident's response to each dose of medication.

At 9:50 a.m. on 7/5/17, operator/licensed nurse B confirmed he/she did not document the resident's behavior, action taken, and results of the action including complete documentation of administration of topical lorazepam.

Operator/licensed nurse B failed to ensure the record of resident #2030 contained documentation of incidents and behaviors including the date, time of occurrence, action taken, and results of the action.

- Record review for resident #2040 revealed an admission date of 4/19/11 and diagnoses of cerebral atrophy and osteoporosis.

Functional capacity screen dated 9/2/16 indicated resident required physical assistance with bathing, dressing, toileting, transferring, and mobility per wheelchair; experienced impaired short-term memory, long-term memory, memory recall, and decision making; and was at risk for falls.

Negotiated service agreement dated 9/2/16 documented services of assistance with bathing, dressing, toileting, and ambulation.

Health care service plan dated 9/2/16 documented physical assistance with all activities of daily living including one-person transfer assistance and to propel wheelchair.

At 12:51 p.m. on 7/3/17, operator/licensed nurse B stated resident slid out of wheelchair last evening and (licensed nurse E) came to facility to

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{S5251}	Continued From page 18 assess resident for injuries. Resident ' s record lacked documentation of the resident's fall and licensed nurse assessment. Operator/licensed nurse B confirmed the resident's record lacked documentation of the incident and action taken. Operator/licensed nurse B failed to ensure the record of resident #2040 contained documentation of incidents and behaviors including the date, time of occurrence, action taken, and results of the action.	{S5251}		