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	B087095	A. BUILDING: _____ B. WING _____	R 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES INC #441	441 S MORNINGSIDE STREET WICHITA, KS 67218

(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 are the result of a Special Revisit at the above named Home Plus Facility in Wichita, Kansas on 5/30/17, 5/31/17, and 6/01/17.	{S 000}		
{S5028} SS=E	26-42-101 (f) (3) Staff Treatment of Residents Reporting (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: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (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. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	{S5028}		

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

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{S5028}	Continued From page 1 KAR 26-42-101(f)(3)(C) The census equalled five the sample included three Residents and one focused review completed. Based on interview and reviews of record, for one focused review cognitively impaired Resident with injury/wound to elbow, and with unwitnessed fall, (#1089), the Operator failed to ensure the incidents thoroughly investigated to rule out potential abuse or neglect, reported as required, and failed to maintain a written record of thorough investigations. Findings included: - Review of record revealed #1089 admitted to facility 5/03/16 with diagnoses of Dementia, Depression, and Anxiety. The current 5/03/16 functional capacity screen (FCS) assessed #1089 in need of physical assistance with bathing and toileting; in need of supervision with dressing and eating; independent with transfers and mobility; with bladder incontinence; impaired short term and long term memory, impaired decision making and memory recall; understands usually understood for communication; with falls/unsteadiness, vision impairment, hearing impairment, and used a walker. The current 5/03/16 negotiated service agreement (NSA) and health service plan (HSP) documented #1089 to receive: A Mechanical Soft diet, bathing assistance, moderate assistance with toileting, laundry, dressing assistance; used 4 wheel walker - supervision - unsteady at times - reminders to use walker; assure glasses on daily; medication management. The NSA and HSP lacked an	{S5028}		

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{S5028}	Continued From page 2 individualized fall prevention plan. By observation on 5/30/17 at 4:50pm, Certified Staff #H served evening meal to Residents... upon completion of meal, #1089 unsteady and grasping onto table and nearby chair when attempting to get out of chair independently and position self with walker to leave table. Medical Record Nurses' Notes revealed: 4/23/17 - 2:49pm - CMA (certified medication aide) found Resident up walking with walker at 0800 on 4/22/17... CMA noted blood on bed, floor, and bathroom floor, this writer was notified and came out to assess, Resident noted with small puncture hole to left elbow area, bleeding has stopped, Resident denies pain to the area, cleansed with normal saline, applied dry bandage... notified medical services, management, and family... writer looked all over room, house, bathroom and walker and did not find anything with blood or sharp to puncture skin. Will continue to monitor. 5/02/17 - 10:14am - ...call from caregiver at 0531 reporting Resident was on floor beside bed... staff stated had been assisting another Resident and heard "thud" went to check on Resident and was laying on floor beside bed... caregiver reported yesterday Resident seemed more confused... will get urine sample The medical record lacked evidence of thorough assessments of Resident at the time of these incidents, thorough investigation of causal factors, and review or revision of NSA or HSP with interventions to address the recent injury and fall.	{S5028}		

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{S5028}	Continued From page 3 By interview on 6/01/17 at 9:21am, Operator/LPN (licensed practical nurse) #B reported cause of injury to elbow unknown... #B emailed an incident report... by review this incident report not a thorough investigation of an unwitnessed injury. By review this unwitnessed injury not reported to the Department as required. By review, a "Fall Investigation" form of the 5/02/17 fall lacked: Signature of who completed the investigation form Last time Resident observed before the fall, by whom, and what he/she doing at the time The last time Resident toileted (according to FCS with assistance) Witness information (left blank) An assessment of increased confusion prior to the fall An assessment of Resident's response to a recent new medication Documentation of attempt or inquiry to determine what Resident was doing when either incident occurred Assessment of #1089's ongoing ability to transfer/ambulate independently Clarification of how Resident both "fell out of bed" and was using walker Clarification of how a bed alarm intended to prevent Resident from falling out of bed This form failed to demonstrate a thorough investigation completed. The Operator failed to ensure the unwitnessed incidents of cognitively impaired #1089 thoroughly investigated to rule out neglect or abuse, and failed to maintain documentation of a thorough investigation to rule out neglect or abuse.	{S5028}		

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S5055	Continued From page 4	S5055		
S5055 SS=D	26-42-101 (l) Survey Report l) Survey report and plan of correction. Each administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a common area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(l) The census equalled five the sample included three Residents and one focus review completed. Based on observations and interviews, for one of one entrance tour completed, the Operator failed to ensure a copy of the most recent survey report available in a common area to Residents and any other individuals wishing to examine survey results. Findings included: - By observation on 5/30/17 at 2:00pm, Certified Staff #H searched for the last Survey report. The notebook, referenced by the posted notice of survey location, lacked the most recent report of 4/12/17. This notebook contained a 2015 Survey Report as the most recent. On 5/30/17 at 2:20pm, Operator/Licensed Nurse #B arrived and confirmed the most recent Survey report not posted or available in facility. Operator/License Nurse #B retrieved the 4/12/17 Survey report from his/her personal bag/briefcase carried into facility upon arrival, hole punched the document, and placed it in the referenced Survey Report notebook.	S5055		

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S5055	Continued From page 5 The Operator failed to ensure a copy of the most recent Survey report available in the facility and available to any individual wishing to examine survey results.	S5055		
{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 census equalled five the sample included three Residents, and one focused review completed. Based on observations, interviews, and reviews of record, for two of three sampled (#1085 and #1089), the Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident, in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Review of record revealed #1085 admitted 3/06/17 with diagnoses of Dementia, Parkinson's,	{S5155}		

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{S5155}	Continued From page 6 Coronary artery disease, Hyperlipidemia, Depression, and Anxiety. The current functional capacity screen (FCS) of 3/06/17 recorded #1085 in need of physical assistance with bathing; supervision with dressing and toileting; independent with transfers, mobility, and eating; unable to perform medication and treatment management; understandable and usually understands for communication; with short term memory, long term memory, memory recall, and decision making impairments; wandering and inappropriate behaviors. The 3/06/17 NSA recorded services to be provided for meals, bathing, toileting, laundry, dressing, grooming, ambulation, hearing, vision, sleeping, housekeeping, lodging, transportation, health care services, medication administration, behavior management, and, outside resources. The 3/06/17 HSP (health service plan) recorded: On a Regular diet generally eats at least 50% of meals Bath aide two times a week Generally continent, will tell staff when needs bathroom Minimal assistance getting clothes out, cueing Grooming with set up and cueing Ambulation, can walk around home without difficulty but tires on long distances and may need wheelchair for outing. A handwritten note added 3/28/17 "PT (physical therapy) Evaluate and treat - periods of unsteadiness, Parkinson's" A hand written note added 3/17/17 "Has been exit seeking - alarm on back door to patio to alert staff when Resident goes outside" Hand written notes added 3/23/17 "Keypad lock placed on back bedroom door East end of home"	{S5155}		

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{S5155}	Continued From page 7	{S5155}		

and "Frequent checks on resident"
A hand written note added 4/03/17 "Public sexual behavior - redirect Resident to his/her room when exhibiting such behaviors"
The NSA and HCP lacked individualized interventions to interest and occupy #185, and to distract from exit seeking desire.

Observations of #1085 on 5/30/17 revealed:
2:00pm to 3:00pm - watching TV in living room, up to wander both halls and used bathroom
3:00pm to approximately 3:30pm - observed in house musical performance
3:59pm - #1085 to front door and tried to open door to leave
4:00pm - sat on piano bench briefly, then back to door to try again
4:20pm - #1085 outside to back yard through door in kitchen area... staff outside to walk and talk with #1085... back inside to watch TV in living room... up at intervals to walk around facility... not observed engaged in any conversation or activity, nothing offered to interest or occupy #1085...
4:40pm - #1085 assisted with setting table for evening meal with supervision
5:20pm - watching TV in living room

Medical record Nurses' Notes from (prior Resurvey) 4/12/17 to 5/30/17 included one entry:

5/02/17 - 1:19pm - seen by ARNP (advanced registered nurse practitioner)... discussed behaviors have improved some, less exit seeking, still continues to increase towards afternoon evening with high anxiety... receives PRN (as needed) Ativan (an anti-anxiety medication) as needed which is usually effective... new order to increase dose of noon Seroquel (anti psychotic medication) to 50mg.

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{S5155}	Continued From page 8 By interview on 5/30/17 at 4:30pm, Operator/LPN (licensed practical nurse) #B confirmed no other Nurses' Notes in record for that time period. When asked if any other documentation, #B stated we have communication notes completed by direct care staff... these not included in the medical record... we keep for awhile before we get rid of them... Communication Notes: 4/11/17 - not a good day, trying to go out window, looking for knifes, fighting with staff 4/12/17 - a little agitated, twisted my arm and wanted to leave, refused dinner 4/13/17 - wanted to go out garage door, going through all drawers 4/14/17 - took off back door lock with screwdriver 4/16/17 - #1085 urinating everywhere... soaked clothes... refused toilet 4/17/17 - kept trying to get out, very agitated, would not let him/her go into kitchen 4/18/17 - bad evening, kept fighting with me about different things 4/19/17 - was upset after finding knife and tried to open door/window 4/22/17 - tried getting out for most of evening 4/23/17 - all clothes out of closet, ready to leave, started pacing, 6pm pacing 4/24/17 - took nail out of window in bedroom and tried leaving, nurse came by with maintenance to fix it 4/27/17 - asked to leave several times, wouldn't go to bed 5/01/17 - very very agitated and anxious at 4:00pm, called nurse and gave "prn" (as needed medication) 5/02/17 - slept until 11:00, fell in kitchen 5/10/17 - good evening, wanted to leave 5/11/17 - stood by garage door for and hour stated waiting on ride	{S5155}		

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{S5155}	Continued From page 9 5/13/17 - wanted to go home 5/16/17 - trying to pry doors open 5/19/17 - not listening today 5/22/17 - tried to get out front door when shower aide left 5/25/17 - refused shower, was very tired after trying to leave 5/29/17 - agitated after lunch, got knife out of drawer, got it back, refused meds By interview on 5/30/17 at 5:25pm, Direct Care Staff #J stated for #1085 has been napping a lot recently... some medications were changed... not trying to leave like was before... redirect and try to distract when displaying attempt to leave... like outside today was going to climb over fence... distracted to another area of yard... have locks on drawers so he/she can't get knife or screwdriver... sometime nurse has us give a "prn" By review, the NSA and the HSP lacked any notes, changes, or interventions added since 3/23/17, in spite of ongoing, additional displays of attempts to elope, agitation, incontinence, and refusal of meals, medications, services. The Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #1085, in regard to fall prevention, individualized activities or interests to dissuade from pacing, agitation, anxiety, and exit seeking. - Review of record revealed #1089 admitted to facility 5/03/16 with diagnoses of Dementia, Depression, and Anxiety. The current 5/03/16 functional capacity screen (FCS) assessed #1089 in need of physical	{S5155}		

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{S5155}	Continued From page 10	{S5155}		

assistance with bathing and toileting; in need of supervision with dressing and eating; independent with transfers and mobility; with bladder incontinence; impaired short term and long term memory, impaired decision making and memory recall; understands usually understood for communication; with falls/unsteadiness, vision impairment, hearing impairment, and used a walker.

The current 5/03/16 negotiated service agreement (NSA) and health service plan (HSP) documented #1089 to receive:
A Mechanical Soft diet, bathing assistance, moderate assistance with toileting, laundry, dressing assistance; used 4 wheel walker - supervision - unsteady at times - reminders to use walker; assure glasses on daily; medication management. The NSA and HSP lacked an individualized fall prevention plan.

On 5/30/17 at 4:50pm, Certified Staff #H served evening meal to Residents... upon completion of meal, #1089 unsteady when attempting to get out of chair independently and position self with walker to leave table.

Medical Record Nurses' Notes revealed:

4/23/17 - 2:49pm - CMA (certified medication aide) found Resident up walking with walker at 0800 on 4/22/17... CMA noted blood on bed, floor, and bathroom floor, this writer was notified and came out to assess, Resident noted with small puncture hole to left elbow area, bleeding has stopped, Resident denies pain to the area, cleansed with normal saline, applied dry bandage... notified medical services, management, and family... writer looked all over room, house, bathroom and walker and did not

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{S5155}	Continued From page 11 find anything with blood or sharp to puncture skin. Will continue to monitor. 5/02/17 - 10:14am - ...call from caregiver at 0531 reporting Resident was on floor beside bed... staff stated had been assisting another Resident and heard "thud" went to check on Resident and was laying on floor beside bed... caregiver reported yesterday Resident seemed more confused... will get urine sample The Nurses' Notes lacked evidence of thorough assessment of Resident at time of the incidents, or reassessment of Resident's current abilities. The available NSA and HSP, more than a year old, lacked evidence of review or new preventative interventions to address the recent injury on 4/23/17 and fall on 5/02/17. An investigation report form dated 5/02/17 recorded the addition of a bed alarm, but not added to the NSA or HSP. By interview on 6/01/17 at 9:21am, Operator/LPN #B stated I would have added the bed alarm to the significant change FCS, NSA, and HSP completed in 3/27/17... I have that on my computer... it has to be at the house somewhere... not sure why the 5/03/16 the only one available when you were reviewing the chart 5/30/17... confirmed the copy provided from time of admission and did not include new interventions after the unwitnessed injury to elbow and the unwitnessed fall... stated the bed alarm would tell us if #1089 fell out of bed if placed the long way and movement across it detected... The Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #1089, in regard to fall and accident	{S5155}		

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{S5155}	Continued From page 12 prevention, and recent increase in confusion.	{S5155}		
{S5185} SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The census equalled five the sample included three Residents and one focused review completed. All Residents received meal service. Based on observations, interview, and record review, for one focus review Resident with a therapeutic diet order (#1089), the Operator failed to ensure the diet prepared according to written instructions from a medical care provider or licensed dietician in accordance with the NSA. Findings included: - Review of record revealed #1089 admitted to	{S5185}		

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{S5185}	Continued From page 13 facility 5/03/16 with diagnoses of Dementia, Depression, and Anxiety. The current 5/03/16 functional capacity screen assessed #1089 in need of physical assistance with bathing and toileting; in need of supervision with dressing and eating; independent with transfers and mobility; with bladder incontinence; impaired short term and long term memory, impaired decision making and memory recall; understands usually understood for communication; with falls/unsteadiness, vision impairment, hearing impairment, and used a walker. The 5/03/16 negotiated service agreement documented #1089 to receive: "a Mechanical Soft diet." On 5/30/17 at 4:50pm, Certified Staff #H served evening meal to Residents: Grilled cheese sandwich, potato chips, watermelon, and red gelatin with fruit. By observation, #1089 ate all the gelatin and fruit, one or two bites of watermelon, a few bites from center of grilled cheese, none of the chips. Resident declined to answer when asked if he/she wanted something else to eat, or if he/she liked the meal or had enough to eat. On 5/30/17 at 5:20pm, Operator/LPN (license practical nurse) #B searched cupboards in kitchen for written instructions and provided two photocopied pages, one page titled "Ground Diet" and one page titled "Pureed Diet." Neither of these descriptive pages contained a signature by a physician or a dietician. By further review, the listed foods "not allowed" for "Ground" included: no cheese slices... no sandwiches... no potato chips... no fresh fruits...	{S5185}		

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	B087095	A. BUILDING: _____ B. WING _____	R 06/01/2017

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{S5185}	Continued From page 14 with seeds... no regular bread unless evaluated and approved... The listed foods "not allowed" for "Pureed" included: no cheese... no fresh fruits... no non smooth grain products, cheese bread, rolls, french toast or other similar foods... no gelatins... no chips... On 5/30/17 at 5:20pm, Operator/LPN #B confirmed the meal served to #1089 did not follow either diet list offered for review and these diets (Ground and Pureed) were not mechanical soft... #B stated we had a Dietician at the other building... I know he/she approved that building's menus... have nothing here approved by a physician or dietician for mechanical soft... The Operator failed to ensure the diet for #1089 prepared according to written instructions from a medical care provider or licensed dietician.	{S5185}		
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 census equalled five the sample included three Residents and one focused review completed. Based on observations, interview and review of record, for one of three sampled	S5251		

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S5251	Continued From page 15 (#1085), the Operator failed to ensure the 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. Findings included: - Review of record revealed #1085 admitted 3/06/17 with diagnoses of Dementia, Parkinson's, Coronary artery disease, Hyperlipidemia, Depression, and Anxiety. The current functional capacity screen (FCS) of 3/06/17 recorded #1085 in need of physical assistance with bathing; supervision with dressing and toileting; independent with transfers, mobility, and eating; unable to perform medication and treatment management; understandable and usually understands for communication; with short term memory, long term memory, memory recall, and decision making impairments; wandering and inappropriate behaviors. The 3/06/17 NSA and HSP (health service plan) recorded services to be provided to meet the Resident's needs. Observations of #1085 on 5/30/17 from revealed: 2:00pm to 3:00pm - watching TV in living room, up to wander both halls and used bathroom 3:59pm - #1085 to front door and tried to open door to leave 4:00pm - sat on piano bench briefly, then back to door to try again 4:20pm - #1085 outside to back yard through door in kitchen area... staff outside to walk and talk with #1085... back inside to watch TV in living room... up at intervals to walk around facility... not observed engaged in conversation or activity,	S5251		

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S5251	Continued From page 16 nothing offered to interest or occupy #1085... Medical record Nurses' Notes from 4/12/17 (prior Resurvey) to 5/30/17 included one entry: 5/02/17 - 1:19pm - seen by ARNP (advanced registered nurse practitioner)... discussed behaviors have improved some, less exit seeking, still continues to increase towards afternoon evening with high anxiety... receives PRN (as needed) Ativan (an anti-anxiety medication) as needed which is usually effective... new order to increase dose of noon Seroquel (anti psychotic medication) to 50mg. By interview on 5/30/17 at 4:30pm, Operator/LPN (licensed practical nurse) #B confirmed no other Nurses' Notes in record for that time period. When asked if any other documentation, #B stated we have communication notes completed by direct care staff... these not included in the medical record... we keep for awhile before we get rid of them... confirmed these notes not a part of the permanent legal record. Communication Notes: 4/11/17 - not a good day, trying to go out window, looking for knifes, fighting with staff 4/12/17 - a little agitated, twisted my arm and wanted to leave, refused dinner 4/13/17 - wanted to go out garage door, going through all drawers 4/14/17 - took off back door lock with screwdriver 4/16/17 - #1085 urinating everywhere... soaked clothes... refused toilet 4/17/17 - kept trying to get out, very agitated, would not let him/her go into kitchen 4/18/17 - bad evening, kept fighting with me about different things 4/19/17 - was upset after finding knife and tried to	S5251		

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S5251	Continued From page 17 open door/window 4/22/17 - tried getting out for most of evening 4/23/17 - all clothes out of closet, ready to leave, started pacing, 6pm pacing 4/24/17 - took nail out of window in bedroom and tried leaving, nurse came by with maintenance to fix it 4/27/17 - asked to leave several times, wouldn't go to bed 5/01/17 - very very agitated and anxious at 4:00pm, called nurse and gave "prn" (as needed medication) 5/02/17 - slept until 11:00, fell in kitchen 5/10/17 - good evening, wanted to leave 5/11/17 - stood by garage door for and hour stated waiting on ride 5/13/17 - wanted to go home 5/16/17 - trying to pry doors open 5/19/17 - not listening today 5/22/17 - tried to get out front door when shower aide left 5/25/17 - refused shower, was very tired after trying to leave 5/29/17 - agitated after lunch, got knife out of drawer, got it back, refused meds These behaviors, interactions, a fall, refusals of care, demonstrations of symptoms of anxiety, any assessments completed, not recorded in the medical record with date, time, symptoms, actions taken and results of actions, as required. By interview on 6/01/17 at 9:21am, Operator/LPN #B stated the "fall" referenced in communication notes was reviewed on camera, and we determined #1085 lowered self to floor, not considered a fall. The Operator failed to ensure for #1085 the documentation of all incidents, symptoms, the	S5251		

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S5251	Continued From page 18 date, time of occurrence, action taken, and results of the action.	S5251		
{S5335} SS=E	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 The census equalled five the sample include three Residents and one focused review completed. The facility identified five with impaired cognitive status. Based on observations and interviews, for cognitively impaired Residents, family members, or visitors to facility, the Operator failed to ensure: Each home plus equipped and maintained to protect the health and safety of Residents, personnel, and the public, in regard to the digital keypad locking mechanisms on Resident room doors. Findings included: - During the entrance tour of facility on 5/30/17 at 2:10pm and at 3:00pm, observed digital keypad locking mechanisms on two Resident room doors. The room with digital lock on the West end	{S5335}		

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{S5335}	Continued From page 19 of facility occupied and the room with digital lock on the East end of facility unoccupied. The Resident room at the far West end of facility observed with a closed and locked door. The door frame contained a sign with #1070's care needs posted by door "I need help with transfers... I eat breakfast good... not so much dinner... if you talk to me I can talk and laugh back..." The door knob of room door observed to be a digital keypad mechanism. On 5/30/17 at 3:00pm Certified Staff #H unlocked the room by entering the digital code. Surveyor confirmed door handle released from inside of room when locked. When asked how emergency personnel or other visitors would get into room in the event of fire or such disaster, Certified Staff #H pointed to a small, discreet piece of tan masking tape on upper left corner of door frame with digital code to door. This code included "star (asterisk)" after a four digit number, but the digital key pad lacked a "star/asterisk." This discreet piece of tape with code not obvious in a general approach to the door. The digital locking mechanism determined to be battery operated. Surveyor requested door be unlocked with key. When asked to unlock the door with a key, Certified Staff #H attempted each individual key on his/her key ring. None of these keys successful in unlocking the door. Certified Staff #H went to kitchen in search of the key... located a key in the cupboard with charts and other books... returned to door, and unlocked the door. This delay in opening the door viewed as significant in the event of: A fallen or injured Resident calling for help from inside the room	{S5335}		

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{S5335}	Continued From page 20 Staff on duty not aware of key location or unable to find Impending emergencies such as tornado, gas leak, and fire On 5/30/17 at 5:43pm, Operator/LPN (licensed practical nurse) #B confirmed piece of tape with code placed because no one without the digital code would be able to get into room in an emergency unless they obtained the key... stated the digital door lock has been there for some time... other inspections have taken place with no mention... confirmed the lock placed on this door due to #1085 wandering and to prevent #1085 from eloping through this room as he/she did from another room in facility. On 5/31/17 at 10:44am and at 12:11pm requested (by email and phone message) facility policy and procedure and/or staff training in regard to digital door locks. No policy and procedure provided as of 2:00pm on 5/31/17. Contacted Operator/LPN (licensed practical nurse) #B again, received message at 2:53pm, we do not have a policy and procedure or staff training regarding digital door locks. The Operator failed to ensure the home plus equipped and maintained to protect the health and safety of Residents, personnel, and the public, in regard to the locking mechanism of Resident room doors that did not allow immediate access by anyone in an emergency.	{S5335}		
{S5350} SS=E	28-39-437 Building Interior (e) General building interior. (1) Resident bedrooms.	{S5350}		

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{S5350}	Continued From page 21 (A) Each resident shall be provided a separate bed with the following: (i) A clean, comfortable mattress; and (ii) bedding appropriate to the weather. (B) Each facility shall provide visual privacy for each resident in a multi-bed room. (C) A space of at least three feet shall be provided between beds in a multi-bed room. (D) Each resident shall be provided with space for the storage of personal items. (E) There shall be at least one window to the outside. (F) Resident bedrooms shall be not be located in a basement. (G) Bedrooms for residents who require physical assistance in transferring from a bed to a wheelchair shall be located on the first floor of the facility. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 The census equalled five the sample included three Residents, and one focused review completed. Based on observations and interviews, for two of three sampled (#1072 and #1085), the Operator failed to ensure full visual privacy provided for each Resident in a multi-bed room, related to the absence of room divider, curtain, screen, or other mechanism to ensure privacy between Residents in a shared room.	{S5350}		

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{S5350}	Continued From page 22 Findings included: - By observation on 5/30/17 at 2:10pm, during the entrance tour, a room on the North side of the West hall, housed two Residents, #1085 and #1072. The room contained two beds, two closets, two bedside stands, and two upright dressers. The room lacked a mechanism for assuring the privacy of either Resident while laying in bed, dressing and undressing, receiving any medical or nursing treatment, or visiting with a guest. The room lacked tracks or rods to support a privacy curtain, the room lacked screens or other physical partitions to position for privacy. On 5/30/17 at 2:10pm, Certified Staff #H searched for screen or other privacy component under beds in room and in closets. Certified Staff confirmed not aware of any items used to provide privacy in facility. On 5/30/17 at 3:54pm, Operator/LPN (licensed practical nurse) #B stated I told maintenance to bring a screen... those two (#1072 and #1085) don't go in their room... no personal care in room... hope Maintenance didn't bring it to another house... #B stated we have one other "double room" in facility, but currently only one Resident in that room. The Operator failed to ensure full visual privacy provided for each Resident, #1085 and #1072, in a multi-bed room.	{S5350}		