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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey of the above home plus facility on 3/9/17, 3/13/17, and 3/14/17.	S 000		
S5065 SS=E	26-42-200 (a) Resident Criteria (a) The administrator or operator of each home plus shall ensure the development and implementation of written admission, transfer, and discharge policies that protect the rights of each resident, pursuant to K.A.R. 26-39-102. In addition, the administrator or operator shall ensure that any resident who has one or more of the following conditions is not admitted or retained unless the negotiated service agreement includes services sufficient to meet the needs of the resident: (1) Incontinence, if the resident cannot or will not participate in management of the problem; (2) immobility, if the resident is totally dependent on another person ' s assistance to exit the building; (3) any ongoing condition requiring two or more persons to physically assist the resident; (4) any ongoing, skilled nursing intervention needed 24 hours a day; or (5) any behavioral symptom that exceeds manageability. This REQUIREMENT is not met as evidenced by: KAR 26-42-200(a)(2) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observations, and interview for 2 (#200 and #300) of 3 residents sampled, the operator failed to ensure each resident who was totally	S5065		

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

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dependent on another person's assistance to exit the building was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident.

Findings included:

- Record review for resident #200 revealed an admission date of 1/14/11 and diagnoses of stroke with left hemiparesis (weakness of left side of body), osteoporosis, and hypertension.

Nurse's notes contained documentation by licensed nurse D that resident experienced a fall resulting in a fractured femur as follows:

2/21/17 at 4:15 p.m. certified staff called this nurse to report resident slipped out of recliner on to knees. Licensed nurse D in facility and resident complains of left knee pain. Resident able to bend left leg at knee. Resident assisted up to wheelchair without difficulty. Resident's family member here and did not want resident evaluated in emergency department. Tylenol administered for pain relief.

2/22/17 at 10:00 a.m. resident complained of left knee pain and left knee swollen with limited range of motion. Medical care provider ordered mobile x-ray.

2/22/17 at 4:30 p.m. x-ray results show minimally displaced, minimally impacted fracture. Medical care provider recommended resident go to emergency department. Resident's family member refused and wants resident seen by an orthopedic medical care provider.

Note: radiology report dated 2/22/17 documented fracture of the distal left femur.

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S5065	Continued From page 2 3/2/17 at 2:20 p.m. resident returned to facility from appointment with orthopedic medical care provider. New orders of no weight bearing and hinged knee brace to left knee. Functional capacity screen dated 9/12/16 indicated resident required physical assistance with mobility and to transfer. Negotiated service agreement dated 9/14/16 documented services of 1 to 2-person assistance with transferring and physical assistance with mobility per wheelchair. At 1:22 p.m. on 3/9/17 surveyor observed resident in wheelchair in dining room. Licensed nurse B finished feeding lunch to resident and instructed certified staff E and certified staff H to transfer resident to recliner in living room. Observed certified staff E and certified staff H transfer resident from wheelchair to recliner. Resident had a brace to left leg that extended above and below the left knee. Certified staff H supported resident's left leg to prevent resident from bearing weight on that leg during transfer. At 4:16 p.m. on 3/9/17, licensed nurse B stated resident required total assistance of one certified staff to exit the building and confirmed the resident's negotiated service agreement lacked a description of this service. The operator failed to ensure resident #200 who was totally dependent on another person's assistance to exit the building was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident.	S5065		

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S5065	Continued From page 3 - Record review for resident #300 revealed an admission date of 10/1/14 and diagnoses of type 2 diabetes mellitus, dementia, coronary artery disease, and osteoarthritis. Functional capacity screen dated 10/1/15 indicated resident required physical assistance with transferring and mobility. Record lacked an annual functional capacity screen. Negotiated service agreement/health care service plan dated 10/1/15 and 10/1/16 each documented the service of 1 to 2-person transfer assistance and assistance with mobility per wheelchair. At 12:10 p.m. on 3/9/17, surveyor observed resident sitting in an upright recliner in living room. Resident slouched down in chair with head resting on right arm of chair and resident's bottom on edge of chair. Certified staff H and certified staff E transferred resident from recliner to wheelchair. Resident did not stand and bear weight during the transfer. Certified staff mobilized wheelchair to dining room for meal. Resident did not attempt to mobilize wheelchair. At 4:33 p.m. on 3/9/17, licensed nurse B stated resident would require total assistance to exit building. Resident's negotiated service agreement lacked the service of resident's total dependence on another person's assistance to exit the building; The operator failed to ensure resident #300 who was totally dependent on another person's assistance to exit the building was not retained unless the negotiated service agreement included services sufficient to meet the needs of the	S5065		

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S5065	Continued From page 4 resident.	S5065		
S5080 SS=E	26-42-201 (a) (b) Functional Capacity Screen on Admission (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. 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. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 2 (#200 and #300) of 3 residents sampled, the licensed nurse failed to ensure the facility's functional screening form included all elements and definitions as specified by the department. Findings included:	S5080		

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S5080	Continued From page 5 - Record review for resident #200 revealed an admission date of 1/14/11 and diagnoses of stroke with left hemiparesis, hypertension, and osteoporosis. Record contained a functional capacity screen (FCS) dated 9/1/15 that lacked the following sections as required by the department: Section III Current problems and risks Section IV Mobility appliances/devices Section V Activities of daily living/instrumental activities of daily living Section VI Medications Section VII Ordered therapies and treatments Section II D. Cognition--Memory recall on the FCS includes short-term memory, long-term memory, memory/recall, and decision making. Functional capacity screen manual instructs person completing the screen to score each area with a "0" if resident does not have a deficit and "1" if resident has a deficit. Licensed nurse completing the FCS did not score each area with a "0" or "1." Record contained an FCS dated 9/12/16 completed by licensed nurse B. The FCS form lacked section V Activities of daily living/instrumental activities of daily living. In section II D cognition--memory recall, licensed nurse B scored a "1" beside "memory/recall" but did not score short-term memory, long-term memory, and decision making. At 5:30 p.m. on 3/9/17, licensed nurse B confirmed the FCS forms did not contain all elements and definitions as specified by the department. For resident #200, the licensed nurse failed to	S5080		

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ensure the facility's functional screening form included all elements and definitions as specified by the department.

- Record review for resident #300 revealed an admission date of 10/1/14 and diagnoses of type 2 diabetes mellitus, dementia, coronary artery disease, and osteoarthritis.

Record contained a functional capacity screen (FCS) dated 10/1/15 that lacked the following sections as required by the department:
Section III Current problems and risks
Section IV Mobility appliances/devices
Section V Activities of daily living/instrumental activities of daily living
Section VI Medications
Section VII Ordered therapies and treatments

Section II D. Cognition--Memory recall on the FCS includes short-term memory, long-term memory, memory/recall, and decision making. Functional capacity screen manual instructs person completing the screen to score each area with a "0" if resident does not have a deficit and "1" if resident has a deficit. Licensed nurse completing the FCS did not score each area with a "0" or "1."

On 3/9/17, licensed nurse B completed an FCS. The form lacked section V Activities of daily living/instrumental activities of daily living.

At 5:30 p.m. on 3/9/17, licensed nurse B confirmed the FCS forms did not contain all elements and definitions as specified by the department.

For resident #300, the licensed nurse failed to ensure the facility's functional screening form

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S5080	Continued From page 7 included all elements and definitions as specified by the department.	S5080		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(1) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview for 1 (#300) of 3 residents sampled, the licensed nurse failed to conduct a screening to determine the resident's functional capacity at least once every 365 days. Findings included: - Record review for resident #300 revealed an admission date of 10/1/14 and diagnoses of type 2 diabetes mellitus, dementia, coronary artery disease, and osteoarthritis. Record contained a functional capacity screen dated 10/1/15 that indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating; was	S5085		

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S5085	Continued From page 8 unable to perform management of medications and treatments; was occasionally incontinent of urine; and was legally blind. The record lacked a more recent functional capacity screen. On 3/9/17 at 3:57 p.m. licensed nurse B stated he/she did not conduct an annual functional capacity screen. The licensed nurse failed to conduct a screening to determine the resident #300's functional capacity at least once every 365 days.	S5085		
S5155 SS=G	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 7 residents. The sample included 3 residents. Based on record review, interview, and observation for 2 (#200 and #300) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to promote wound healing and prevent further skin breakdown. Residents #200	S5155		

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and #300 each developed a stage 2 (skin breaks open exposing deeper layers of skin) pressure ulcer. Based on record review, observation, and interview for 2 (#200 and #300) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address each resident's risk for falls. Based on record review, observation, and interview for 2 (#100 and #200) of 3 residents sampled, the operator failed to ensure the licensed nurse assessed the safety of a bed rail and resident ' s ability to safely use the bed rail as a positioning device.

Findings included:

- Record review for resident #200 revealed an admission date of 1/14/11 and diagnoses of stroke with left hemiparesis (weakness of left side of body), osteoporosis, and hypertension.

Functional capacity screen dated 9/1/15 indicated resident required physical assistance with mobility and to transfer; occasionally incontinent of urine; and lacked a score for cognition.

Record contained a negotiated service agreement/health care service plan (NSA/HCSP) dated 9/18/15 that documented services of physical assistance with transfers and mobility in wheelchair and that resident was incontinent at times. The NSA/HCSP lacked interventions to address resident's risk for skin breakdown due to limited mobility and urinary incontinence.

Nurse's notes contained documentation by licensed nurses that resident experienced skin breakdown as follows:

7/27/16 certified staff reports resident complains

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of heels hurting when in bed. Resident has one-half dollar size blisters present to both heels. Notified medical care provider and received order to swab both heels with Betadine (skin antiseptic) two times a day, float heels (to relieve pressure), and resident to not wear shoes.

(The NSA/HCSP lacked interventions to treat skin breakdown and promote wound healing)

8/9/16 areas healed and no open skin on heels. Will continue to offload heels a little longer.

The annual functional capacity screen dated 9/12/16 indicated the resident continued to require physical assistance with mobility, was occasionally incontinent of urine, and experienced impaired memory recall.

NSA/HCSP dated 9/14/16 documented services of physical assistance with transfers and mobility in wheelchair and that resident was incontinent of urine at times. The NSA/HCSP lacked interventions to address resident's ongoing risk for skin breakdown due to limited mobility and urinary incontinence

Nurse ' s notes contained documentation by licensed nurses that resident experienced a fall on 2/21/17 resulting in a fractured femur.

The NSA/HCSP continued to lack interventions to address resident #200 ' s risk for skin breakdown.

Nurse's notes contained documentation by licensed nurses that resident experienced additional skin breakdown as follows:

3/7/17 at 9:00 a.m. licensed nurse D

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documented resident had developed " 4 circular areas, 1 1/2 inch each, bedsores." Medical care provider ordered Calmoseptine (a combination ointment with an analgesic, antiseptic, antipruritic, and a skin protectant) applied 3 times a day and as needed to the area.

The NSA/HCSP continued to lack interventions to address the risk for skin breakdown and interventions to promote wound healing.

Observations of resident on 3/9/17:

9:44 a.m. resident in bed in room resting with eyes closed and head of bed elevated approximately 35 to 40 degrees. Observed a raised half bed rail on each side of bed.

Note: NSA/HCSP lacked documentation of purpose of bed rails.

1:22 p.m. resident in wheelchair in dining room. Licensed nurse B finished feeding lunch to resident and instructed certified staff E and certified staff H to transfer resident to recliner in living room. Observed certified staff E and certified staff H transfer resident from wheelchair to recliner. Resident had a brace to left leg that extended above and below the left knee. Certified staff H supported resident's left leg to prevent resident from bearing weight on that leg during transfer. Surveyor observed a pressure relieving cushion on the seat of the wheelchair but no pressure relieving cushion placed in the recliner.

2:56 p.m. certified staff F and certified staff G transferred resident from recliner in living room to wheelchair and mobilized resident to the

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resident's room. Certified staff F and certified staff G then transferred resident to bed and positioned resident on right side. Licensed nurse B stated resident had a memory foam mattress. Licensed nurse B lifted resident's left buttock to reveal a stage 2 pressure ulcer on resident's inner right buttock by coccyx. Licensed nurse B stated open area was the size of a quarter. Wound bed moist and red in color with moist discolored lighter area surrounding wound. Surveyor unable to observe area for other open wounds due to resident's positioning and room lighting. Licensed nurse B applied an ointment in between resident's buttocks.

At 2:38 p.m. on 3/9/17, certified staff E stated he/she applied cream to the resident's bottom, kept resident clean and dry, repositioned resident, and applied heel protectors when resident in bed as interventions to prevent skin breakdown.

At 4:09 p.m. on 3/9/17, licensed nurse B stated interventions to address resident's risk for skin breakdown as therapeutic mattress, check resident every 2 hours and provide incontinence care if needed, heel protectors, and float heels to keep pressure off heels. Licensed nurse B confirmed the resident's NSA/HCSP lacked these interventions. Licensed nurse B stated resident used the bed rails to assist with positioning. Licensed nurse B stated he/she did not assess resident's ability to safely use the bed rails and did not assess the safety of the bed rail.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to resident #200 that included interventions to promote wound healing and prevent further skin breakdown, and

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determine resident's ability to safely use bed rails and the safety of the bed rails. Resident #200 experienced skin breakdown on bilateral heels in August 2016 and the licensed nurse further failed to implement interventions to address skin breakdown. The resident experienced a fractured femur from a fall 2/21/17 which further limited his/her mobility and developed 4 pressure wounds two weeks later.

- Record review for resident #300 revealed an admission date of 10/1/14 and diagnoses of type 2 diabetes mellitus, dementia, coronary artery disease, and osteoarthritis.

Functional capacity screen dated 10/1/15 indicated resident required physical assistance with transferring and mobility; was frequently incontinent of urine; and lacked a score for cognition. Record lacked an annual functional capacity screen.

Negotiated service agreement/health care service plan (NSA/HCSP) 10/1/16 lacked interventions to address the risk of skin breakdown due to resident's immobility and urinary incontinence.

Nurse's notes contained documentation that resident experienced skin breakdown as follows:

2/10/17 at 10:00 a.m. by licensed nurse B that resident had area of skin breakdown 1/2 dime size above coccyx. Licensed nurse documented will apply barrier cream and monitor.

Observations of resident on 3/9/17:

12:10 p.m. resident sitting in an upright recliner in living room. Resident slouched down in chair with head resting on right arm of chair and resident's

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bottom on edge of chair. Certified staff H and certified staff E transferred resident from recliner to wheelchair. Resident did not stand and bear weight during the transfer. Surveyor observed a pressure relieving cushion in wheelchair but no pressure relieving cushion in recliner.

5:10 p.m. in north hall bathroom, certified staff F and certified staff G assisted resident from toilet and supported resident before transferring to wheelchair. Surveyor observed an approximately 1.5 centimeter round stage 2 pressure ulcer on inner left buttock.

At 2:34 p.m. on 3/9/17, certified staff E stated interventions to prevent skin breakdown included positon change at least every 2 hours and keep resident clean and dry.

At 4:35 p.m. on 3/9/17, licensed nurse B stated the resident's NSA/HCSP lacked interventions related to risk for skin breakdown, and wound healing.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to resident #300 that included interventions to address the risk for skin break down, promote wound healing and prevent further skin breakdown..

- Record review for resident #100 revealed an admission date of 6/23/16 and diagnoses of type 2 diabetes mellitus and dementia.

Functional capacity screen dated 6/23/16 indicated resident required physical assistance with toileting; supervision with transferring and ambulation; experienced impaired short-term

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	B087145	A. BUILDING: _____ B. WING _____	03/14/2017

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BETHEL HOUSE	1316 CHARLOTTE STREET WICHITA, KS 67208

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memory, decision making, and memory recall; and was at risk for falls.

Negotiated service agreement/health care service plan dated 6/23/16 documented services of physical assistance with toileting, stand-by assistance with mobility due to history of falls, and use of a body alarm.

Nurse's notes contained documentation by licensed nurses of falls experienced by resident:

7/19/16 resident got out of bed and fell. Resident had removed body alarm.

10/23/16 resident lost balance in bathroom and fell.

2/5/17 resident fell around 1:00 a.m. when getting up to go to bathroom without help. Resident had removed body alarm.

At 9:42 a.m. observed the room of resident #100 and the resident's hospital bed with a half bed rail on outer side of bed and other side of bed against the wall. Surveyor observed that the bed rail was lowered and upside down.

At 2:47 p.m. on 3/9/17 along with certified staff E went to resident's room to look at the bed rail. Bed rail still lowered but with end of rail at the head of bed angled down toward the floor. Surveyor applied pressure to rail at other end and rail easily flipped down to floor at that end. Certified staff E stated resident used the bed rail to hold onto when sitting up in bed and getting out of bed.

At 2:50 p.m. on 3/9/17, licensed nurse B stated resident used the bed rail as a positioning device.

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S5155	Continued From page 16 Surveyor demonstrated to licensed nurse B that bed rail moved back and forth freely when pressure applied to either end of rail. Licensed nurse B raised mattress from bed frame and surveyor observed 2 metal bars across the frame connecting a bed rail on each side of the bed. The bed rails were not securely attached to the bed frame. During an interview at 4:09 p.m. on 3/9/17, licensed nurse B stated he/she did not assess the safety of the bed rail and the resident's ability to safely use the bed rail as a positioning device. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to resident #100 that included an assessment of the safety of a bed rail and resident ' s ability to safely use the bed rail as a positioning device.	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.	S5185		

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S5185	Continued From page 17 This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#100) of 3 residents sampled, the operator failed to ensure resident received a mechanically altered diet and thickened liquids prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #100 revealed an admission date of 6/30/16 and diagnoses of type 2 diabetes mellitus and dementia. Functional capacity screen dated 6/23/16 indicated resident was independent with eating. Negotiated service agreement dated 6/23/16 documented the service of a mechanical soft diet and nectar thick liquids with instruction to observe resident for pocketing of food. Nurse's notes contained an entry by licensed nurse B dated 8/23/16 that resident was seen by speech therapist that recommended a pureed diet with nectar thick liquids. Medical care provider wrote an order for resident to receive a mechanically altered diet and nectar thick liquids. Observed resident drinking thickened liquid at 12:27 p.m. on 3/9/17 and eating meal of Salisbury steak cut into small pieces, rice with gravy, and	S5185		

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S5185	Continued From page 18 cooked broccoli, cauliflower, and carrots. At 3:47 p.m. on 3/9/17, licensed nurse B stated certified staff did not have instructions from a medical care provider or licensed dietitian to follow when preparing resident's meals and thickened liquids. The operator failed to ensure resident #100 received a mechanically altered diet and thickened liquids prepared according to instructions from a medical care provider or licensed dietitian.	S5185		
S5251 SS=D	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 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#300) of 3 residents sampled, the licensed nurse failed to ensure the resident's record contained documentation of all indications of injury including the action taken and results of the actions. Findings included: - Record review for resident #300 revealed an	S5251		

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admission date of 10/1/14 and diagnoses of type 2 diabetes mellitus, dementia, coronary artery disease, and osteoarthritis.

Functional capacity screen dated 10/1/15 indicated resident required physical assistance with toileting, transferring, and mobility; was frequently incontinent of urine; and unable to perform management of medications and treatments. Record lacked an annual functional capacity screen.

Negotiated service agreement/health care service plan dated 10/1/15 and 10/1/16 documented physical assistance with toileting, transferring, and mobility and facility management of medications and treatments.

Nurse's notes contained an entry dated 2/10/17 at 10:00 a.m. by licensed nurse B that resident had area of skin breakdown 1/2 dime size above coccyx. Licensed nurse documented will apply barrier cream and monitor.

The record lacked documentation of subsequent nursing assessments of the wound and the response to treatment.

At 4:25 p.m. on 3/9/17, licensed nurse B stated he/she had looked at resident's wound since 2/10/17 but had not documented an assessment.

On 3/9/17 at 5:10 p.m. in north hall bathroom, surveyor observed certified staff F and certified staff G assist resident from toilet and support resident before transferring to wheelchair. Surveyor observed an approximately 1.5 centimeter round stage 2 pressure ulcer (skin breaks open exposing deeper layers of skin) on inner left buttock.

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S5251	Continued From page 20 The licensed nurse failed to ensure resident #300's record contained documentation of all indications of injury including the action taken and results of the actions.	S5251		
S5258 SS=F	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(1) The facility reported a census of 7 residents. The	S5258		

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S5258	Continued From page 21 sample included 3 residents. Based on interview and record review for all residents, the person designated as having authority and responsibility to oversee the adult care home failed to register as an operator as required by KSA 39-975. Findings included: - At 10:13 a.m. on 3/9/17, licensed nurse B stated employee C was the facility operator. Licensed nurse B stated he/she was unsure if employee C completed registration as an operator. A check of the Kansas Department for Aging and Disability Services web site for Health Occupations Credentialing License/Registration Verification did not show this individual registered as an operator of an adult care home. The person designated as having authority and responsibility to oversee the adult care home failed to register as an operator as required by KSA 39-975.	S5258		