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	B087206	A. BUILDING: _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES INC #219	219 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 represent the findings of a resurvey of the above home plus facility on 3/1/17, 3/2/17, 3/6/17, 3/7/17, and 3/8/17.	S 000		
S5026 SS=G	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 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review, observation, and interview for 1 (#300) of 3 residents sampled, the operator failed to ensure the resident was not subjected to neglect when the licensed nurse failed to assess the resident's risk for skin breakdown, implement health care services to prevent skin breakdown and promote wound healing, and notify medical care provider immediately when resident developed signs of skin breakdown. Resident #300 developed a stage 4 pressure ulcer (a wound extending into muscle and bone). Findings included:	S5026		

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

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S5026	Continued From page 1 - Record review for resident #300 revealed an admission date of 8/21/15 and diagnoses of Parkinson's disease and dementia. Admission functional capacity screen dated 8/21/15 indicated resident was independent with eating; required supervision with toileting and transferring; physical assistance with bathing, dressing, and mobility; unable to self-manage medications and treatments; experienced daily incontinence of urine; experienced impaired short-term memory and memory recall; was at risk for falls; and used a walker as an assistive device with ambulation. Negotiated service agreement/health care service plan (NSA/HCSP) dated 8/21/15 documented facility staff provided physical assistance with bathing, resident has Parkinson's and is unsteady with ambulation using walker, and resident wore briefs for daily incontinence of urine. NSA/HCSP lacked interventions to prevent skin breakdown. Record contained a Braden Risk Skin Assessment (used to evaluate a person's risk to develop a pressure ulcer) dated 8/21/15 that did not show resident to be at risk for development of a pressure ulcer. The record lacked ongoing nursing assessments of the resident's risk for skin breakdown. The record contained an annual functional capacity screen dated 8/19/16 that was scored the same as the admission functional capacity screen dated 8/21/15 with the exception of resident now experienced impaired decision making ability. Annual NSA/HCSP dated 8/19/16 documented	S5026		

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S5026	Continued From page 2	S5026		

same health care services as in NSA/HCSP dated 8/21/15.

At 9:37 a.m. on 3/1/17, observed resident in bed in the resident's room with a half side rail up on each side of the bed and a padded mat on floor on left side of bed. During time in facility on 3/1/17 and 3/2/17, observed resident in bed, in wheelchair in dining room, or in recliner in living room. Surveyor did not see certified staff reposition resident other than when transferred from wheelchair to bed or chair. Surveyor did not observe resident walking or transferring self as indicated in functional capacity screen and NSA/HCSP.

Nurse's notes contained the following entries:

12/3/16 at 7:59 p.m. licensed nurse C documented as a late entry for 11/30/16 that caregiver reported resident had an area on coccyx dark in color with redness surrounding. Caregiver reported resident had a decrease in mobility with difficulty standing and ambulating. Called medical care provider for order to contact hospice for evaluation of resident.

12/6/16 at 3:05 p.m. licensed nurse C documented resident's admission to hospice.

12/16/16 at 3:23 p.m. licensed nurse C documented caregivers report resident had elevated temperature. Tylenol given. Wound to coccyx has increased in size with a lot of drainage. Hospice will continue to follow.

1/10/17 at 5:28 p.m. by licensed nurse C that hospice is following wound to coccyx which is larger, no improvement, and has necrotic tissue present. Medical care provider debrided

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S5026	Continued From page 3	S5026		

(removed dead, damaged, or infected tissue) wound and cultured wound. Medical care provider ordered antibiotic and probiotic.

1/20/17 at 2:24 p.m. by licensed nurse C that medical care provider here to debride wound and gave order for resident to receive morphine (narcotic medication for moderate to severe pain) 30 minutes prior to wound care.

1/26/17 at 5:04 p.m. by licensed nurse C that medical care provider and hospice nurse evaluated wound today. Medical care provider debrided wound.

2/3/17 at 2:46 p.m. by licensed nurse C medical care provider ordered antibiotic and probiotic after wound culture results obtained.

The NSA/HCSP lacked revision to add and implement health care services to promote wound healing and to prevent further skin breakdown.

Record contained the following medical care provider notes:

12/20/16 resident seen for recent hospice admission due to decline in dementia and Parkinson's disease. Resident not ambulating and requires more assistance with activities of daily living. Stage 2 (skin breaks open exposing deeper layers of skin) wound to coccyx with hospice applying Duoderm (gel type dressing to absorb wound drainage) dressing every 7 days. Resident has lost weight noted by visible temporal wasting (muscles of temporal bones) and thinner face. Staff unable to weigh resident.

1/10/17 resident seen to debride wound. Hospice

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S5026	Continued From page 4	S5026		

nurse reported wound to coccyx much larger and lots of drainage. Stage 4 pressure ulcer to coccyx with sharp debridement to cut out large amount of yellow/gray exudate (drainage). Wound with tunneling at 6:00 o'clock position at least 2 centimeters. Wound to be packed with NuGauze (gauze strip). Wound cultured. Increase tramadol (narcotic-like medication to treat moderate to severe pain) to three times a day. Resident started on antibiotic.

Note: record contained wound culture results of mixed flora with no further workup required.

1/20/17 wound looking slightly better but still has a lot of drainage with foul odor. Dressing changed every day with application of Santyl debridement gel. Did get an air mattress to help with pressure on wound. Large stage 4 pressure wound with large amount of dark grey, black exudate to wound bed with foul odor from wound. Continue tramadol three times a day and give morphine 5 milligrams sublingual before dressing change.

1/26/17 wound has stalled in healing process and hospice nurse reports wound is looking worse. Area around wound opening now with redness and excoriation. To apply moisture barrier cream and antifungal cream around wound opening. Sharp debridement of wound to cut out exudate. Discontinue Santyl gel and pack wound with anti-microbial gauze strip. Continue tramadol and morphine prior to wound care. Eating and drinking well.

2/15/17 Stage 4 sacral wound slightly better with drainage not as foul smelling but still a lot of drainage requiring daily dressing change. Add thin layer of collagen (protein that stimulates new

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S5026	Continued From page 5	S5026		

tissue growth) to wound bed and continue to pack wound with ant-microbial gauze strip then cover with foam dressing covered with gauze pads to absorb drainage. Daily dressing change and will re-evaluate in 2 weeks.

Hospice licensed nurse documented wound assessments as follows:

12/28/16 wound to coccyx measures 4.5 centimeters (cm) by 3.8 cm with irregular edges. Yellow slough in wound. Red area surrounding wound measuring 6 cm.

1/10/17 medical care provider present for wound debridement. Wound now measures 5 cm by 4 cm with tunneling at 6:00 to 7:00 o'clock position that measures 2 cm. Wound with irregular edges and 7.5 cm by 8 cm redness surrounding wound. Stage 4 wound will now be treated.

1/20/17 assisted medical care provider with debridement of wound. Wound depth at center 4 cm and 3 cm at 6:00 to 7:00 o'clock position. Wound measures 4 cm by 5 cm with irregular edges.

2/15/17 wound measures 3 cm by 3 cm and 3 cm deep at 6:00 to 7:00 o'clock position and 2 cm deep at center of wound. Large amount of fairly odorous drainage.

2/28/17 wound measures 2 cm by 2.4 cm with surrounding reddened area 4.5 cm by 5 cm. Depth of wound at center 1 cm and at 6:00 to 7:00 o'clock area 3 cm.

At 11:09 a.m. on 3/2/17, observed certified staff D administer morphine to resident and then take resident to his/her room in wheelchair. By 11:16

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a.m. certified staff D had assisted resident to toilet and then assisted resident to bed. Certified staff D stated resident could not walk and required physical assistance of one person to transfer and toilet. Certified staff D stated prior to wound opening he/she applied barrier cream to skin "where it looked like a huge bone....like (his/her) tailbone was sticking out and then the skin broke down." Certified staff D stated he/she repositioned resident frequently "more than every 2 hours."

At 11:45 a.m. on 3/2/17 observed hospice licensed nurse M provide wound care to resident who was positioned on right side in bed. Open wound located on resident's lower sacrum/coccyx area. Hospice licensed nurse M cleansed wound bed with wound cleanser, used gauze to clean inside wound, placed a piece of collagen by tunneled area of wound, filled wound with antimicrobial gauze strip, covered wound with 2 folded absorbent gauze pads, and then covered wound and perimeter of wound with a transparent adhesive dressing. Hospice licensed nurse stated resident received wound care daily by a hospice nurse. During procedure resident moaned when the nurse touched the wound and stated repeatedly "Kill me...you are killing me." Surveyor observed air mattress on bed and cushion in wheelchair as pressure relieving devices.

At 4:29 p.m. on 3/2/17, licensed nurse C stated caregiver notified him/her of a reddened area beside a raised area on resident's sacrum. When surveyor asked licensed nurse C for the date he/she was notified of this, he/she referred to pictures he/she had taken with phone and stated the date was 11/17/16. Surveyor viewed the pictures and observed one picture showing the

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S5026	Continued From page 7 raised area on resident's sacrum and a picture of the red area. Licensed nurse C stated he/she notified medical care provider on 11/30/16 (as documented in the nurse's notes entry dated 12/3/16) of the change in resident's skin condition. Licensed nurse C stated he/she discussed hospice services with the medical care provider on 11/30/16 due to resident's signs of skin breakdown. Licensed nurse C confirmed hospice services did not start until 12/6/16. Licensed nurse C confirmed he/she did not put interventions into place to address resident's risk for skin breakdown prior to or when resident exhibited signs of skin breakdown. The operator failed to ensure the resident was not subjected to neglect when the licensed nurse failed to assess the resident's risk for skin breakdown, implement health care services to prevent skin breakdown and promote wound healing, and notify medical care provider immediately when resident developed signs of skin breakdown.	S5026		
S5065 SS=D	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;	S5065		

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S5065	Continued From page 8 (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 9 residents. The sample included 3 residents. Based on record review, observations, and interviews for 1 (#300) of 3 residents sampled, the operator failed to ensure a resident who required total 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 #300 revealed an admission date of 8/21/15 and diagnoses of Parkinson's disease and dementia. Functional capacity screen dated 8/19/16 indicated resident required supervision with toileting and transferring; physical assistance with mobility; used a walker as an assistive device with ambulation; and experienced impaired short-term memory, decision making, and memory recall. Negotiated service agreement/health care service plan (NSA/HCSP) dated 8/19/16 documented	S5065		

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resident has Parkinson's and is unsteady with ambulation using walker and "in the event of an emergency, resident can exit building using (his/her) walker with stand-by assist of one."

Nurse's notes contained an entry by licensed nurse C at 7:59 p.m. on 12/3/16 as a late entry for 11/30/16 that caregiver reported resident had a decrease in mobility with difficulty standing and ambulating.

Record contained documentation by the medical care provider on 12/20/16 that resident was seen for recent hospice admission due to decline in dementia and Parkinson's disease. Resident not ambulating and requires more assistance with activities of daily living.

At 9:37 a.m. on 3/1/17, observed resident in bed in the resident's room with a half side rail up on each side of the bed and a padded mat on floor on left side of bed. During time in facility on 3/1/17 and 3/2/17, observed resident in bed, in wheelchair in dining room, or in recliner in living room. Surveyor did not observe resident walking or transferring self as indicated in functional capacity screen.

At 11:09 a.m. on 3/2/17, observed certified staff D mobilize resident in wheelchair from the dining room to the resident's room. By 11:16 a.m. certified staff D had assisted resident to toilet and then assisted resident to bed. Certified staff D stated resident could not walk and required physical assistance of one person to transfer and toilet.

At 4:29 p.m. on 3/2/17, licensed nurse C stated resident #300 could not walk and required physical assistance to toilet and transfer with

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S5065	Continued From page 10 mobility per wheelchair. The NSA/HCSP lacked documentation services sufficient to meet the needs of resident #300 who was totally dependent on another person's assistance to exit the building. The operator failed to ensure resident #300 who required total assistance to exit the building was not retained unless the negotiated service agreement included services sufficient to meet the needs of the resident.	S5065		
S5066 SS=D	26-42-200 (b) Resident Criteria Restraints (b) Each administrator or operator shall ensure that any resident whose clinical condition requires the use of physical restraints is not admitted or retained. This REQUIREMENT is not met as evidenced by: KAR 26-42-200(b) The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review, observation, and interview for 1 (#300) of 3 residents sampled, the operator failed to ensure that a resident whose clinical condition required the use of a physical restraint was not retained. Findings included: - Record review for resident #300 revealed an admission date of 8/21/15 and diagnoses of	S5066		

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S5066	Continued From page 11 Parkinson's disease and dementia. Functional capacity screen dated 8/19/16 indicated resident required supervision with toileting and transferring; physical assistance with mobility; used a walker as an assistive device with ambulation; was at risk for falls; and experienced impaired short-term memory, decision making, and memory recall. Negotiated service agreement/health care service plan (NSA/HCSP) dated 8/19/16 documented facility staff provided physical assistance with bathing, resident has Parkinson's and is unsteady with ambulation using walker, and use of a bed alarm and padded mat on floor beside bed due to resident's risk for falls. Nurse's notes contained an entry by licensed nurse C at 7:59 p.m. on 12/3/16 as a late entry for 11/30/16 that caregiver reported resident had a decrease in mobility with difficulty standing and ambulating. Record contained documentation by the medical care provider on 12/20/16 that resident was seen for recent hospice admission due to decline in dementia and Parkinson's disease. Resident not ambulating and requires more assistance with activities of daily living. At 9:37 a.m. on 3/1/17, observed resident in bed in the resident's room with a half side rail up on each side of the bed and a padded mat on floor on left side of bed. During time in facility on 3/1/17 and 3/2/17, observed resident in bed, in wheelchair in dining room, or in recliner in living room. Surveyor did not observe resident walking or transferring self as indicated in functional capacity screen.	S5066		

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S5066	Continued From page 12 At 11:16 a.m. certified staff D assisted resident to toilet and then assisted resident to bed with a half side rail pulled up on each side of resident. Certified staff D stated resident needed bed rails because resident would get out of bed when anxious and that resident would climb over rails. At 11:24 a.m. on 3/2/17, licensed nurse C stated resident did not have bed rails on bed. Licensed nurse C went to resident's room and observed resident in bed with half side rail up on each side of resident. Certified staff D stated he/she thought side rails were to be used to prevent resident from falling from bed and staff members used the half side rails since hospice delivered the bed. (Admitted to hospice 12/6/16.) The operator failed to ensure that resident #300 whose clinical condition required the use of a physical restraint was not retained.	S5066		
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)(2)	S5085		

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S5085	Continued From page 13 The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review, observations, and interviews for 1 (#300) of 3 residents sampled, the licensed nurse failed to conduct a screening to determine the resident's functional capacity when resident experienced a significant change in condition. Findings included: - Record review for resident #300 revealed an admission date of 8/21/15 and diagnoses of Parkinson's disease and dementia. Functional capacity screen dated 8/19/16 indicated resident was independent with eating; required supervision with toileting and transferring; physical assistance with bathing, dressing, and mobility; unable to self-manage medications and treatments; experienced daily incontinence of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls; and used a walker as an assistive device with ambulation. Nurse's notes contained an entry by licensed nurse C at 7:59 p.m. on 12/3/16 as a late entry for 11/30/16 that caregiver reported resident had an area on coccyx dark in color with redness surrounding. Caregiver reported resident had a decrease in mobility with difficulty standing and ambulating. Called medical care provider for order to contact hospice for evaluation of resident. Record contained documentation by the medical care provider on 12/20/16 that resident was seen	S5085		

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S5085	Continued From page 14	S5085		

for recent hospice admission due to decline in dementia and Parkinson's disease. Resident not ambulating and requires more assistance with activities of daily living. Stage 2 (skin breaks open exposing deeper layers of skin) wound to coccyx with hospice applying Duoderm (gel type dressing to absorb wound drainage) dressing every 7 days. Resident has lost weight noted by visible temporal wasting (muscles of temporal bones) and thinner face. Staff unable to weigh resident.

On 1/10/17 medical care provider documented resident seen to debride wound. Hospice nurse reported wound to coccyx much larger and lots of drainage. Stage 4 pressure ulcer to coccyx with sharp debridement to cut out large amount of yellow/gray exudate (drainage).

At 9:37 a.m. on 3/1/17, observed resident in bed in the resident's room with a half side rail up on each side of the bed and a padded mat on floor on left side of bed. During time in facility on 3/1/17 and 3/2/17, observed resident in bed, in wheelchair in dining room, or in recliner in living room. Surveyor did not observe resident walking or transferring self as indicated in functional capacity screen.

At 11:09 a.m. on 3/2/17, observed certified staff D mobilize resident in wheelchair from the dining room to the resident's room. By 11:16 a.m. certified staff D had assisted resident to toilet and then assisted resident to bed. Certified staff D stated resident could not walk and required physical assistance of one person to transfer and toilet.

At 4:29 p.m. on 3/2/17, licensed nurse C stated resident #300 could not walk, required physical

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S5085	Continued From page 15 assitance to toilet and transfer, and mobility per wheelchair. The licensed nurse failed to conduct a screening to determine the resident's functional capacity when resident #300 experienced a significant change in condition.	S5085		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2)(3) The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review, interview, and observation for 1 (#300) of 3 residents sampled, the operator failed to ensure the development of a written negotiated	S5105		

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service agreement based on the resident's health care service needs that included a description of the services the resident would receive; identification of the provider of each service; and identification of each party responsible for payment when an outside resource provided the service.

Findings included:

- Resident roster documented resident #300 received services from an outside provider.

Record review for resident #300 revealed an admission date of 8/21/15 and diagnoses of Parkinson's disease and dementia.

Functional capacity screen dated 8/19/16 indicated resident was independent with eating; required supervision with toileting and transferring; physical assistance with bathing, dressing, and mobility; unable to self-manage medications and treatments; experienced daily incontinence of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls; and used a walker as an assistive device with ambulation.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 8/19/16 documented facility staff provided physical assistance with bathing, resident has Parkinson's and is unsteady with ambulation using walker, and resident wore briefs for daily incontinence of urine. The NSA/HCSP lacked documentation of services provided by an outside resource.

Nurse's notes contained an entry by licensed nurse C at 7:59 p.m. on 12/3/16 as a late entry for 11/30/16 that caregiver reported resident had an

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S5105	Continued From page 17	S5105		

area on coccyx dark in color with redness surrounding. Caregiver reported resident had a decrease in mobility with difficulty standing and ambulating. Called medical care provider for order to contact hospice for evaluation of resident. On 12/6/16, licensed nurse C documented hospice evaluated resident and resident to receive hospice services.

Record contained documentation by the medical care provider on 12/20/16 that resident was seen for recent hospice admission due to decline in dementia and Parkinson's disease. Resident not ambulating and requires more assistance with activities of daily living. Stage 2 (skin breaks open exposing deeper layers of skin) wound to coccyx with hospice applying Duoderm (gel type dressing to absorb wound drainage) dressing every 7 days. Resident has lost weight noted by visible temporal wasting (muscles of temporal bones) and thinner face. Staff unable to weigh resident.

At 11:45 a.m. on 3/2/17 observed hospice licensed nurse M provide wound care to resident who was positioned on right side in bed. Surveyor observed an open stage 4 wound located on resident's lower sacrum/coccyx area. Hospice licensed nurse M stated a hospice nurse visited resident every day to provide wound care. Hospice home health aide N stated he/she visited resident 3 times a week for bathing and personal care services.

At 4:17 p.m. on 3/2/17, licensed nurse C provided hospice documentation of visits made and services provided to resident. Documentation included social work and chaplain visits in addition to skilled nursing and home health aide visits. Licensed nurse C confirmed hospice

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S5105	Continued From page 18 services not described in the resident's NSA/HCSP. The operator failed to ensure the development of a written negotiated service agreement for resident #300 based on the resident's health care service needs that included a description of the services the resident would receive; identification of the provider of each service; and identification of each party responsible for payment when an outside resource provided the service.	S5105		
S5115 SS=D	26-42-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(c) The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review and interview for 1 (#400) of 1 focus review resident, the operator failed to ensure the development of an initial negotiated service agreement at admission. Findings included: - Record review on 3/2/17 for resident #400 revealed an admission date of 3/1/17 and diagnoses of traumatic brain injury and multiple sclerosis.	S5115		

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S5115	Continued From page 19 Record contained a functional capacity screen dated 2/15/17 that indicated resident required physical assistance with bathing and dressing; supervision with toileting, transferring, and mobility; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and used a walker as a mobility device. The record lacked a negotiated service agreement. At 11:00 a.m. on 3/2/17, licensed nurse C stated he/she did not develop a negotiated service agreement with the resident upon admission. The operator failed to ensure the development of an initial negotiated service agreement with resident #400 at admission.	S5115		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement 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; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.	S5116		

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S5116	Continued From page 20 This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review, observations, and interviews for 1 (#300) of 3 residents sampled, the licensed nurse failed to revise the negotiated service agreement following a significant change in condition. Findings included: - Record review for resident #300 revealed an admission date of 8/21/15 and diagnoses of Parkinson's disease and dementia. Functional capacity screen dated 8/19/16 indicated resident was independent with eating; required supervision with toileting and transferring; physical assistance with bathing, dressing, and mobility; unable to self-manage medications and treatments; experienced daily incontinence of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls; and used a walker as an assistive device with ambulation. Negotiated service agreement/health care service plan (NSA/HCSP) dated 8/19/16 documented facility staff provided physical assistance with bathing, resident has Parkinson's and is unsteady with ambulation using walker, and resident wore briefs for daily incontinence of urine. Nurse's notes contained an entry by licensed nurse C at 7:59 p.m. on 12/3/16 as a late entry	S5116		

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S5116	Continued From page 21	S5116		

for 11/30/16 that caregiver reported resident had an area on coccyx dark in color with redness surrounding. Caregiver reported resident had a decrease in mobility with difficulty standing and ambulating. Called medical care provider for order to contact hospice for evaluation of resident.

Record contained documentation by the medical care provider on 12/20/16 that resident was seen for recent hospice admission due to decline in dementia and Parkinson's disease. Resident not ambulating and requires more assistance with activities of daily living. Stage 2 (skin breaks open exposing deeper layers of skin) wound to coccyx with hospice applying Duoderm (gel type dressing to absorb wound drainage) dressing every 7 days. Resident has lost weight noted by visible temporal wasting (muscles of temporal bones) and thinner face. Staff unable to weigh resident.

On 1/10/17 medical care provider documented resident seen to debride wound. Hospice nurse reported wound to coccyx much larger and lots of drainage. Stage 4 pressure ulcer to coccyx with sharp debridement to cut out large amount of yellow/gray exudate (drainage).

At 9:37 a.m. on 3/1/17, observed resident in bed in the resident's room with a half side rail up on each side of the bed and a padded mat on floor on left side of bed. During time in facility on 3/1/17 and 3/2/17, observed resident in bed, in wheelchair in dining room, or in recliner in living room. Surveyor did not observe resident walking or transferring self as indicated in functional capacity screen.

At 11:09 a.m. on 3/2/17, observed certified staff D

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S5116	Continued From page 22 mobilize resident in wheelchair from the dining room to the resident's room. By 11:16 a.m. certified staff D had assisted resident to toilet and then assisted resident to bed. Certified staff D stated resident could not walk and required physical assistance of one person to transfer and toilet. At 4:29 p.m. on 3/2/17, licensed nurse C stated resident #300 could not walk, required physical assistance to toilet and transfer, and mobility per wheelchair. Licensed nurse C confirmed resident experienced skin breakdown and received hospice services. Licensed nurse C confirmed he/she did not revise the resident's NSA/HCSP following the resident's significant change in condition. The licensed nurse failed to revise the negotiated service agreement following resident #300's significant change in condition.	S5116		
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)	S5155		

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S5155	Continued From page 23 The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review, observations, and interviews for 3 (#200, #100, and #300) of 3 residents sampled, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address each resident's risk for falls as identified on the functional capacity screen Findings included: - Record review for resident #200 revealed an admission date of 1/11/17 and diagnoses of dementia, frequent falls, and vertigo. Functional capacity screen dated 1/11/17 indicated resident required supervision with transferring and walking; physical assistance with bathing, dressing, and toileting; experienced impaired short-term memory, long-term memory, decision making, and memory recall; did not use an assistive device for mobility; and was at risk for falls. Negotiated service agreement/health care service plan (NSA/HCSP) dated 1/11/17 documented assistance with dressing due to resident's instability; supervision with walking and one to two-person assistance as needed with periods of unstable gait; and bed alarm. The NSA/HCSP did not address health care services resident required when transferring. Record contained a fall risk assessment completed by licensed nurse C on 1/11/17 with a score of 11. The form documented that a score greater than 8 indicated resident had a potential	S5155		

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for falling and should have a prevention plan noted on NSA/HCSP.

Record documented resident received warfarin sodium (blood thinning medication) 4 milligrams tablet daily 6 days a week.

Nurse ' s notes contained documentation of falls experienced by resident as follows:

1/18/17 at 7:44 a.m. by licensed nurse E. Certified staff reported to night nurse resident fell in dining room while certified staff assisting another resident and other certified staff in kitchen. Video recording reviewed and resident went to sit in chair, missed chair, and fell. No injury noted.

1/18/17 at 7:59 p.m. by licensed nurse C. Resident voiced some discomfort in low back relieved with Tylenol. "Resident is unsteady at times when ambulating...supervision during these times...resident require to be supervised when sitting down in chair as will not always get positioned right before trying to sit." Note: NSA/HCSP lacked revision to include supervision of resident when transferring.

1/24/17 at 7:59 p.m. by licensed nurse C. Caregiver reported at 1:15 p.m. resident fell in dining room while caregiver assisting another resident in dining room. Reviewed video recording and observed resident fell when sitting in chair. Resident sat on arm of chair tipping the chair over causing resident to fall.

1/28/17 at 11:45 a.m. by licensed nurse E. Pharmacist in facility witnessed resident fall when attempting to sit on loveseat. Resident hit back of head on table and received a 1 inch cut to back of

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head with very little bleeding noted. Range of motion of extremities within normal limits and pupils equal and reactive to light. Family member and medical care provider notified.

2/10/17 at 7:59 p.m. by licensed nurse C. Caregiver called at 2:00 p.m. to report resident fell in dining room when standing up from chair hitting head on wall. Pupils equal and reactive to light and range of motion within normal limits. Cannot open left eye as wide as right eye and eyes fluttering. Medical care provider notified and due to resident hitting head received order to send resident to emergency department for evaluation. Resident returned to facility after test came back negative for bleeding in brain.

2/20/17 at 7:59 p.m. by licensed nurse C. Received call from caregiver at 5:44 p.m. that resident fell in dining room and complained of pain to right hip area. Licensed nurse C went to facility to assess resident who was moving all extremities without discomfort. Skin tear to right wrist.

2/28/17 at 7:59 p.m. by licensed nurse C. Caregiver reported at approximately 12:00 a.m. caregiver in kitchen and observed resident getting up. Caregiver asked resident if he/she was going to sit back down and resident replied "I will when I finish something." and resident then fell to floor.

3/1/17 at 1:01 p.m. by licensed nurse C that resident continues with unsteadiness...more so when goes to stand or sit down. Resident will cross legs when standing causing resident to be off balance. When sitting resident will sit on arm of chair.

The NSA/HCSP lacked revision to add services

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to address resident's inability to transfer self safely resulting in falls.

At 11:27 p.m. on 3/1/17, licensed nurse C stated resident required 1 to 1 attention to reduce resident's risk for falling. Licensed nurse C stated facility could not provide that service.

At 2:25 p.m. on 3/1/17, licensed nurse C stated interventions in place to reduce resident's risk for falls as constant supervision with resident always in sight of employees and use anti-anxiety medication as needed. Licensed nurse C stated the anti-anxiety medication reduced risk for falls because when resident anxious he/she would almost run instead of walk. Licensed nurse C stated there was a bed alarm on resident's bed and sound monitor in room in order to alert staff when resident was up in room. Licensed nurse C stated resident had not fallen in his/her room and that falls occurred when resident getting up from or sitting down in a chair. Licensed nurse C confirmed resident's NSA/HCSP lacked interventions related to resident's risk for falls.

Observed that resident #200 spent time in a chair at the table in the dining room or in a chair in the living room. Observed certified staff worked in the kitchen. Walking into the kitchen from the front door of the facility the dining room was directly to the right with a wide doorway allowing certified staff visibility of the dining room table if facing the dining room doorway. The living room was located straight ahead from the front door through the kitchen with an open area above the kitchen counter allowing certified staff visibility of residents in the living room if facing the living room.
Location of work areas in kitchen clockwise from doorway into dining room:

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COMFORT CARE HOMES INC #219	219 S MORNINGSIDE STREET WICHITA, KS 67218

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Work area with printer/fax machine and resident record storage. Certified staff would be able to look to left and see dining room but not able to see living room.
Refrigerator with visibility of dining room to left and no visibility of living room.
Stove with no visibility to dining room and limited visibility to living room.
Sink and dishwasher limited visibility to dining room and full visibility to living room.
Medication storage closet allowed for no visibility of living room or dining room.

Observations of resident transferring self and ambulating independently without staff member supervision or assistance:

10:47 a.m. on 3/1/17 resident ambulated from living room to dining room. Resident sat down in dining chair forcefully and swayed from side to side with arms of chair preventing resident from falling out of chair. Resident then attempted to stand up from chair. Certified staff D and certified staff F in kitchen instructed resident to sit down.

3:42 p.m. on 3/1/17 resident standing up from chair in living room and unsteady. Surveyor called to certified staff H who was standing in the kitchen but had his/her back to the end of living room where resident had been sitting. Certified staff H instructed and assisted resident to sit back down.

11:10 a.m. on 3/2/17 resident stood from chair in dining room, walked to look out glass door, and then back to sit down in chair. Resident sat on left arm of chair sliding into chair. Observed licensed nurse C, licensed nurse E, the bath aide, certified staff F, and licensed nurse G in the kitchen. None of the employees responded to

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resident to assist with transferring from chair and back into chair. Surveyor informed licensed nurse E of resident not being supervised and licensed nurse E went to resident who was attempting to stand up from chair. Licensed nurse E told resident to sit down but resident wanted to stand and licensed nurse E assisted resident to stand and walked with resident.

By interview at 11:22 a.m. on 3/2/17, licensed nurse C stated staff was unable to supervise resident because certified staff D was assisting another resident and certified staff F was cooking.

Observation at 2:54 p.m. on 3/2/17 resident #200 walked through the room off the living room to the back sliding door with unsteady gait. Surveyor summoned assistance for resident who was opening back door. Certified staff D came from the dining room and walked outside with resident.

By interview at 4:13 p.m. on 3/1/17, certified staff H stated fall interventions for #200 included bed alarm, 1 to 1 supervision, and assistance when standing or sitting.

By interview at 3:58 p.m. on 3/2/17, certified staff J stated resident required staff to be "right there" with him/her to try to prevent resident from falling.

During an interview at 1:10 p.m. on 3/2/17, operator B stated resident #200 was almost to point of needing 1 to 1 supervision to reduce resident's risk for falls and that staff members had tried this. Operator B stated facility staffing pattern of 2 certified staff members on duty on each of the three shifts.

The resident roster listed 9 residents living in the

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facility. All residents required administration of medications and treatments, 3 of 9 residents experienced at least one fall in the last 6 months, 2 of 9 residents required physical assistance with toileting, and all residents required physical assistance with bathing. Surveyor observed during time in facility that 8 of 9 residents were ambulating without a staff member assisting. Resident #300 required a wheelchair and one staff member to mobilize wheelchair and transfer resident. A hospice aide provided bathing assistance to resident #300 and a facility bath aide came to the facility to provide bathing assistance to the other residents. Facility activity employees came to facility to provide activities for residents. A volunteer was present in the home and served the noon meal to residents.

Surveyor observed a certified medication aide on the 7:00 a.m. to 3:00 p.m. shift and the 3:00 p.m. to 11:00 p.m. responsible for administering medications to residents. Surveyor observed certified staff responsible for meal preparation. Certified staff D stated the 11:00 p.m. to 7:00 a.m. shift prepared some food items for the day. Certified staff completed laundry for residents. The 2 certified staff on duty provided toileting assistance to those residents needing assistance, dressing assistance as needed, and for resident #300 mobility and transfer assistance.

Resident #200 received anticoagulant medication and experienced 7 falls from 1/18/17 through 2/28/17 with 2 falls involving head strike. Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address the resident's risk for falls.

- Record review for resident #100 revealed an

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admission date of 12/7/16 and diagnoses of vascular dementia and anxiety.

Functional capacity screen dated 12/7/16 indicated resident was independent with toileting, transferring, and walking; required physical assistance with bathing and dressing; experienced impaired short-term memory, long-term memory, decision making, and memory recall; used a cane as an assistive device when walking; and was at risk for falls.

The negotiated service agreement/health care service plan dated 12/7/16 lacked interventions to address the resident's risk for falls.

Nurse's notes contained documentation by a licensed nurse on 12/26/16 that caregiver called nurse at 4:40 a.m. to report resident fell in bathroom. On 3/1/17 at 1:12 p.m. licensed nurse C documented caregiver called nurse at 9:03 a.m. to report resident was sitting on bed while caregiver was getting clothes for resident. Caregiver reported resident slid off bed and hit right shoulder on wall and head on table. Resident complained of right shoulder pain. Medical care provider ordered X-ray of right shoulder, clavicle, and humerus. Radiology report negative for fracture but showed effusion (seeping of fluid into a body cavity or tissue) of AC joint (acromioclavicular, the joint at the top of the shoulder. It is the junction between a part of the scapula and clavicle). Medical care provider ordered application of ice to area and Tylenol and ibuprofen for pain relief.

Surveyor observed that resident complained of pain in right shoulder throughout the day on 3/1/17 without relief after receiving Tylenol. Resident sat in a recliner and when he/she

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attempted to get up, observed that resident could not use right arm to get out of chair without complaining of pain. Resident required physical assistance to get up from recliner.

At 10:38 a.m. on 3/2/17, observed resident with right arm in sling. Licensed nurse C stated resident's family member took resident to emergency department last evening and was given order for tramadol (a narcotic-like pain reliever for moderate to severe pain) as needed for pain. Emergency department discharge instructions documented a diagnosis of acromioclavicular injury (separated shoulder).

The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address the resident's risk for falls as identified on the functional capacity screen.

- Record review for resident #300 revealed an admission date of 8/21/15 and diagnoses of Parkinson's disease and dementia.

Functional capacity screen dated 8/21/15 indicated resident required physical assistance with walking; supervision with transferring and toileting; used a walker as an assistive device for mobility; experienced impaired short-term memory and memory recall; and was at risk for falls.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 8/21/15 lacked interventions to address resident's risk for falls.

Nurse's notes contained the following documentation of resident ' s falls:

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S5155	Continued From page 32 8/22/15 at 7:59 p.m. licensed nurse C documented caregiver called on 8/21/15 to report he/she heard resident call for help and found resident on floor in resident's room. Resident told caregiver he/she was attempting to get out of chair and fell. 8/29/15 at 3:52 p.m. licensed nurse E documented caregiver called at 6:40 a.m. to report resident fell in room. Continue to remind resident to use monitor to call for assistance. 9/9/15 at 2:10 p.m. licensed nurse E documented caregiver called around 4:00 a.m. to report resident fell in room. Resident stated he/she slipped on way to bathroom. Resident received to scratches to back. Caregivers to continue to encourage resident to ask for assistance with ambulation when unsteady. 9/18/15 at 5:29 p.m. licensed nurse E documented resident fell in room around 4:30 a.m. when getting up to bathroom. Resident received 2 skin tears to left forearm and a skin tear to right arm and voiced tenderness to right shoulder. Tylenol given for pain relief. 10/31/15 at 9:01 p.m. licensed nurse K documented resident fell at 7:55 p.m. when getting ready for bed. Resident complained of pain in bottom and Tylenol given for pain relief. 12/13/15 at 8:41 p.m. licensed nurse K documented resident fell hitting left shoulder on china cabinet and received 2 skin tears to on right wrist. Resident complained of pain in left shoulder. Tylenol given for pain relief. 2/25/16 at 6:42 a.m. licensed nurse L documented caregiver reported resident fell and	S5155		

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landed on bottom while caregiver walking with resident. Resident received a small bruise to right forearm.

7/9/16 at 7:59 p.m. licensed nurse L documented caregiver reported resident fell getting up with walker at approximately 10:02 p.m. Caregiver reported he/she was with resident at the time of the fall. Resident received a skin tear to top of left wrist. Caregivers educated on the importance of using gait belt at all times during transfers.

7/31/16 at 11:58 a.m. licensed nurse C documented caregiver found resident on floor in room between bed and wall at 6:00 a.m. On-call nurse reported resident large bruise to outer aspect of left leg just below knee. Medical care provider ordered X-ray of lower leg. (Radiology report negative for fracture.)

Resident record contained an annual functional capacity screen dated 8/19/16 that indicated resident required physical assistance with walking; supervision with transferring and toileting; used a walker as an assistive device for mobility; experienced impaired short-term memory, decision making, and memory recall; and was at risk for falls.

NSA/HCSP dated 8/19/16 documented fall reduction interventions of bed alarm and mat on floor beside bed.

Nurse's notes contained the following documentation of resident's falls:

8/24/16 at 7:59 p.m. licensed nurse L documented caregiver called to report resident fell at 6:15 a.m. in dining room while caregiver was pulling a chair out for resident.

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S5155	Continued From page 34 10/31/16 at 7:59 p.m. licensed nurse C documented night caregivers reported to the night nurse that an agency caregiver reported at the evening meal he/she had to lower resident to floor. 11/3/16 at 4:57 p.m. licensed nurse C documented night caregivers reported to night nurse that resident complained of pain in left shoulder and this morning caregiver found bruise to left shoulder when giving resident a shower. Medical care provider ordered X-ray of left shoulder to rule out fracture. 11/4/16 at 7:59 p.m. by licensed nurse C that radiology report negative for fracture. At 9:37 a.m. on 3/1/17, observed resident in bed in his/her room with a half side rail up on each side of bed and a padded mat on floor on left side of bed. During an interview at 11:16 a.m. on 3/2/17, certified staff D stated fall reduction interventions of bed alarm and side rails on bed. At 3:50 p.m. on 3/2/17, certified staff J stated fall reduction interventions of monitoring resident and respond promptly if resident yelling or bed alarm was sounding. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address the resident's risk for falls as identified on the functional capacity screen.	S5155		

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S5195	Continued From page 35	S5195		
S5195 SS=E	26-42-206 (f) (g) Facility Food Storage (f) Staff shall store all food under safe and sanitary conditions. Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. (g) Each home shall maintain at least a three-day supply of food to meet the requirements of the planned menus. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(f) The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on observation and interview for all residents, the operator failed to ensure staff members stored food under safe and sanitary conditions. Findings included: - At 9:59 a.m. on 3/1/17 observed a side-by-side refrigerator/freezer in the kitchen. Improper food storage of frozen foods: One bag of broccoli, one bag of cauliflower, and one bag of diced carrots each in the original packaging. Each bag was not sealed or labeled with a date when package was opened. Paper sack of tator tots open at the top and not closed securely or dated when opened. Plastic 1 gallon container one-third full of neopolitan ice cream without the date opened.	S5195		

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S5195	Continued From page 36 Four plastic bags of ground beef. Each bag lacked the identity of the food and the date the original packaging was opened. Certified staff D stated each plastic bag contained one-half of a 10 pound package of ground beef that he/she divided the day before and placed in freezer. Improper storage of refrigerated foods: Partial 16 ounce package of bacon slices with package cut open. The bacon was not stored securely wrapped or dated when opened. Plastic sandwich bag with two-thirds of a green pepper. Plastic sandwich bag with one-half of a red onion. Plastic sandwich bag with one-half of a yellow onion. Plastic bag with a wedge of iceberg lettuce. None of the sandwich bags were labeled with the date the vegetable was placed in the bag and the identity of the food item. A 5 pound cottage cheese plastic container that contained tomato sauce and a 5 pound cottage cheese plastic container that contained diced tomatoes. Each container lacked a label to identify the food item and the date food item placed in the container. Certified staff D stated foods were to be labeled and dated when opened and repackaged. The facility's food storage policy and procedure recorded if frozen food in a large quantity was	S5195		

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S5195	Continued From page 37 divided and repackaged staff were to place in a freezer bag and label with a description of the product and the date repackaged and placed in freezer. Refrigerated foods to be wrapped, covered, or sealed and labeled and dated. The operator failed to ensure staff members stored food under safe and sanitary conditions.	S5195		
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 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on record review, interview, and observation for 1 (#300) of 3 residents sampled, the licensed nurse failed to ensure the resident's record contained documentation of symptoms and indications of injury including the date, time of occurrence, action taken, and results of the action. Findings included: - Record review for resident #300 revealed an admission date of 8/21/15 and diagnoses of Parkinson's disease and dementia.	S5251		

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S5251	Continued From page 38 Functional capacity screen dated 8/19/16 indicated resident was independent with eating; required supervision with toileting and transferring; physical assistance with bathing, dressing, and mobility; unable to self-manage medications and treatments; experienced daily incontinence of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls; and used a walker as an assistive device with ambulation. Negotiated service agreement/health care service plan dated 8/19/16 documented facility staff provided physical assistance with bathing, resident has Parkinson's and is unsteady with ambulation using walker, and resident wore briefs for daily incontinence of urine. At 9:37 a.m. on 3/1/17, observed resident in bed in the resident's room with a half side rail up on each side of the bed and a padded mat on floor on left side of bed. During time in facility on 3/1/17 and 3/2/17, observed resident in bed, in wheelchair in dining room, or in recliner in living room. Surveyor did not observe resident walking or transferring self as indicated in functional capacity screen and NSA/HCSP. Nurse's notes contained an entry by licensed nurse C at 7:59 p.m. on 12/3/16 as a late entry for 11/30/16 that caregiver reported resident had an area on coccyx dark in color with redness surrounding. Caregiver reported resident had a decrease in mobility with difficulty standing and ambulating. Called medical care provider for order to contact hospice for evaluation of resident. Record contained a medical care provider note dated 1/10/17 that resident was seen to debride	S5251		

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wound. Hospice nurse reported wound to coccyx much larger and lots of drainage. Stage 4 pressure ulcer (wound extending into muscle and bone) to coccyx with sharp debridement to cut out large amount of yellow/gray exudate (drainage). Wound with tunneling at 6:00 o'clock position at least 2 centimeters. Wound to be packed with NuGauze (gauze strip). Wound cultured. Increase tramadol (narcotic-like medication to treat moderate to severe pain) to three times a day. Resident started on antibiotic.

Hospice licensed nurse documented a wound assessment 1/10/17 of medical care provider present for wound debridement. Wound now measures 5 cm by 4 cm with tunneling at 6:00 to 7:00 o'clock position that measures 2 cm. Wound with irregular edges and 7.5 cm by 8 cm redness surrounding wound. Stage 4 wound will now be treated.

At 11:16 a.m. certified staff D stated prior to skin opening resident developed an area "where it looked like a huge bone....like (his/her) tailbone was sticking out and then the skin broke down."

At 11:45 a.m. on 3/2/17 observed hospice licensed nurse M provide wound care to resident who was positioned on right side in bed. Surveyor observed an open stage 4 wound located on resident's lower sacrum/coccyx area.

At 4:29 p.m. on 3/2/17, licensed nurse C stated caregiver notified him/her of a reddened area beside a raised area on resident's sacrum. When surveyor asked licensed nurse C for the date he/she was notified of this, he/she referred to pictures he/she had taken with phone and stated the date was 11/17/16. Surveyor viewed the pictures and observed one picture showing the

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S5251	Continued From page 40 raised area on resident's sacrum and a picture of the red area. Licensed nurse C stated he/she notified medical care provider on 11/30/16 (as documented in the nurse's notes entry dated 12/3/16) of the change in resident's skin condition. Licensed nurse C confirmed he/she did not document an assessment of resident's skin on 11/17/16 when notified by certified staff The licensed nurse failed to ensure the record of resident #300 contained documentation of symptoms and indications of injury including the date, time of occurrence, action taken, and results of the action.	S5251		
S5312 SS=E	26-42-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(g)(2) The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on observation and interview for 1 (#200) of 3 residents sampled and 1 (#700) non-sampled discharged resident, the operator failed to ensure each prescription medication container had a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14.	S5312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087206	A. BUILDING: _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES INC #219	219 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
S5312	Continued From page 41	S5312		

Findings included:

- At 1:49 p.m. on 3/2/17, certified staff D removed a metal locked box from the medication refrigerator. The box contained 3 plastic bags that contained 1 milliliter (ml) syringes filled with a medication. One plastic bag held 2 syringes each with 1 ml of a medication and 1 syringe with 0.5 ml of a medication. Second plastic bag held 35 syringes filled with 1 ml of a medication. Some of the syringes had a label with "Lorazepam 1 mg (milligram)/1 ml for topical use only. Expires 6/5/17" The syringes or the plastic bags holding the syringes lacked a label to identify the resident to receive, administration instructions, date filled, and prescribing medical care provider. Certified staff D stated this medication belonged to a discharged resident (resident #700).

The metal box contained a third plastic bag holding 3 syringes total. Two syringes were filled with 1 ml of medication and one syringe with 0.5 ml of medication. The plastic bag contained handwriting with the name of resident #200 and "Ativan topical." Certified staff D stated licensed nurse (C) wrote the resident's name and medication name on the plastic bag.

At 2:18 p.m. on 3/2/17, licensed nurse C stated he/she called pharmacist and was told the pharmacist attached the required label on the plastic bag syringes were sent in to facility. Licensed nurse C stated someone administering the medications apparently placed the syringes in another plastic bag.

The operator failed to ensure each prescription medication container had a label that was

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	B087206	A. BUILDING: _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES INC #219	219 S MORNINGSIDE STREET WICHITA, KS 67218

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S5312	Continued From page 42 provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14.	S5312		
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(a) The facility reported a census of 9 residents. The sample included 3 residents, 1 focus review resident, and 2 closed records reviewed. Based on observation, interview, and record review for all residents, the operator failed to ensure staff members maintained a safe environment for the cognitively impaired residents. Findings included: - During tour of the facility at 9:30 a.m. on 3/1/17, observed a spray bottle of 409 cleaner in an unlocked cabinet in the south hall resident bathroom/shower room. At 9:39 a.m. on 3/1/17, licensed nurse C confirmed that chemicals were to be stored in a locked area.	S5335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087206	A. BUILDING: _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES INC #219	219 S MORNINGSIDE STREET WICHITA, KS 67218

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S5335	Continued From page 43 Review of the resident roster revealed all 9 residents experienced impaired cognition and 6 residents were independent with toileting. The operator failed to ensure staff members maintained a safe environment for the cognitively impaired residents.	S5335		