STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N078015	A. BUILDING: _____ B. WING _____	02/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HUTCHINSON	2416 BRENTWOOD STREET HUTCHINSON, KS 67502

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for the investigation of complaints #110764 and #110822 of the above assisted living facility on 2/14/17, 2/15/17, 2/16/17, 2/20/17, and 2/21/17.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 109 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for 1 (#7) of 6 residents sampled, the administrator failed to ensure allegations of potential abuse and/or neglect were reported to the department within 24 hours of the incident. Findings included: - Record review for resident #7 revealed an admission date of 8/5/16 and diagnoses of type 2 diabetes mellitus, Alzheimer's disease, and arteriosclerotic heart disease. The record contained a functional capacity screen dated 8/5/16 that indicated resident was independent with toileting, transferring, walking; experienced impaired short-term memory; intact long-term memory, decision making and memory recall; was not at risk for falls; and did not utilize an assistive device for mobility. The record contained a negotiated service agreement/health care service plan (NSA/HCSP) dated 8/5/16 that documented services of facility medication management and resident was independent with all activities of daily living. This NSA/HCSP documented resident experienced a fall July 2016 during a hospital stay. The record also contained an NSA/HCSP dated 2/14/17 that documented services of physical assistance with toileting; stand-by assistance ambulating with walker; and to be alert for risk for falls. The NSA/HCSP recorded resident's last fall	S3028		

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S3028	Continued From page 2 on 2/10/17. The record lacked a functional capacity screening that reflected the changes in resident's physical functioning. Resident log notes contained documentation by licensed nurses that resident experienced falls: 12/19/16 at 10:45 a.m. witnessed fall in hallway with abrasions to nose and forehead. Left facility for appointment with medical care provider. 12/19/16 2:00 p.m. returned to facility family member reported nose broken and CT (computerized tomography) of head negative. Note: resident taking blood thinning medications Plavix and aspirin daily. 1/11/17 at 11:00 p.m. resident found lying on floor in hallway. Resident stated someone pushed him/her out of bed. Bruised area above right eye. Transported to hospital emergency department. Admitted to hospital with diagnosis of influenza A. 1/15/17 3:40 p.m. returned to facility and placed on visual check every 2 to 3 hours due to confusion and impulsive behavior. 2/4/17 at 2:00 a.m. staff found resident in apartment on floor leaning against the bathroom door. Multiple skin tears on left elbow. 2/8/17 at 4:35 a.m. staff found resident in apartment on floor on hands and knees. Resident stated he/she was trying to answer the door and fell. Resident stated he/she hit head. Skin tear to right lower arm and resident complained of pain to head, right shoulder and right elbow. Transported to hospital emergency department.	S3028		

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S3028	Continued From page 3 2/8/17 6:35 a.m. admitted to hospital with diagnosis of bradycardia (slow heart rate). 2/10/17 6:10 p.m. returned to facility. 2/10/17 11:37 p.m. at approximately 7:48 p.m. staff found resident on floor of apartment after hearing loud noise from apartment. No injuries noted. Resident stated unable to remember what happened to cause him/her to be on floor. 2/14/17 at 3:15 a.m. found on floor of apartment. Resident denied hitting head or in pain. At 4:15 p.m. on 2/16/17, assistant director of nursing D stated he/she reported resident's fall 12/19/16 to the department but did not report the other times staff found resident on floor. For resident #7, the administrator failed to ensure allegations of potential abuse and/or neglect were reported to the department within 24 hours of the incident.	S3028		
S3066 SS=D	26-41-200 (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 26-41-200(b) The facility reported a census of 109 residents.	S3066		

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S3066	Continued From page 4 The sample included 6 residents and 2 closed records reviewed. Based on record review, observation, and interview for 1 (#5) of 6 residents sampled, the administrator 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 #5 revealed an admission date of 8/9/15 and diagnoses of dementia and diabetes mellitus. Functional capacity screen dated 5/11/16 indicated resident was unable to perform toileting, transferring, and mobility; was incontinent of bowel and bladder; experienced impaired short-term memory, long-term memory, decision making, and memory recall and was at risk for falls. Negotiated service agreement/health care service plans dated 6/21/16 and 11/23/16 each documented services of: Bathroom assistance: toilet every 2 to 4 hours during day and as needed at night. Fall Management Program: resident currently uses a Geri-chair (a mobile recliner for an immobile person). Transfers: Two-person assistance with all transfers. Mobility: resident uses a manual wheelchair as a mobility aid. Resident log notes contained documentation by a licensed nurse at 7:00 p.m. on 11/9/16 that a home health nurse reported to staff that resident was on the floor of apartment. Staff member observed resident lying on left side on floor	S3066		

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S3066	Continued From page 5 beside Geri-chair. Prior to fall, resident had been reclined in Geri-chair. During tour of the memory care unit at 10:30 a.m. on 2/14/17, observed resident #5 sitting in a Geri-chair with a tray attached to each arm of the chair. Observed that resident was alone in room. Administrator B stated he/she did not know if resident could remove tray by self. Resident was unable to answer the question due to impaired cognition. Observed that resident moved arms about without obvious purpose. At 10:42 a.m. on 2/14/17, observed that resident remained alone in apartment in Geri-chair with tray in place. At 10:56 a.m. on 2/14/17, certified staff G stated he/she and another aide brought resident to room in Geri-chair after breakfast. Certified staff G stated tray remained on chair so resident would not fall out of chair. Certified staff G stated it was his/her understanding that tray was to always be on when resident in Geri-chair. At 11:15 a.m. observed a certified employee mobilize resident in Geri-chair into the dining room for meal. An aide placed a plate of food on tray of Geri-chair and resident fed self. During an interview at 1:10 p.m. on 2/14/16, health and wellness coordinator E stated hospice nurse determined resident needed a Geri-chair so resident could recline. Health and wellness coordinator E explained that resident moved arms and could throw self out of a wheelchair. The administrator failed to ensure that a resident whose clinical condition required the use of a physical restraint was not retained.	S3066		

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S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility 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 26-41-201(c)(2) The facility reported a census of 109 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for 1 (#7) of 6 residents sampled, a licensed nurse failed to conduct a functional capacity screen following a significant change in physical functioning and cognitive status. Findings included: - Record review for resident #7 revealed an admission date of 8/5/16 and diagnoses type 2 diabetes mellitus, Alzheimer's disease, and arteriosclerotic heart disease. The record contained a functional capacity screen dated 8/5/16 that indicated resident was independent with bathing, dressing, toileting, transferring, walking, and eating; required supervision with management of medications and treatments; was continent of urine; experienced	S3081		

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S3081	Continued From page 7 impaired short-term memory; intact long-term memory, decision making and memory recall; was not at risk for falls; and did not utilize an assistive device for mobility. The record contained a negotiated service agreement dated 2/14/17 that documented services of physical assistance with medication administration, dressing, grooming, toileting, and urinary incontinence management; stand-by assistance ambulating with walker; and supervision with bathing. The negotiated service agreement recorded that resident experienced short-term memory impairment, long-term memory impairment at times, and memory recall deficit with resident to spend daytime hours in memory care and return to assisted living apartment after evening meal. The negotiated service agreement recorded resident's last fall on 2/10/17. The record lacked a functional capacity screen since the screening dated 8/5/16. At 12:19 p.m. on 2/16/17, health and wellness director C stated resident experienced a significant change in functioning and licensed nurse failed to conduct a functional capacity screening. A licensed nurse failed to conduct a functional capacity screen following a significant change in resident #7's physical functioning and cognitive status.	S3081		
S3130 SS=D	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care	S3130		

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S3130	Continued From page 8 facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met: (1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility. (2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility. (3) A written order from a medical care provider is obtained for admission. (4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility. (5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident. (6) Direct care staff are present in the special care section or facility at all times. (7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records. (8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another	S3130		

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S3130	Continued From page 9 section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section. This REQUIREMENT is not met as evidenced by: KAR 26-41-203(d)(2)(3) The facility reported a census of 109 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review, interview, and observation for 1 (#7) of 6 residents sampled, the administrator failed to ensure prior to the resident spending daytime hours in the memory care unit that the record contained medical care provider's progress notes to justify the time spent in the memory care unit and a written order from a medical care provider for this service, Findings included: - Record review for resident #7 revealed an admission date of 8/5/16 and diagnoses type 2 diabetes mellitus, Alzheimer's disease, and arteriosclerotic heart disease. The record contained a functional capacity screen dated 8/5/16 that indicated resident experienced impaired short-term memory with intact long-term memory, decision making, and memory recall. The record contained a negotiated service agreement dated 2/14/17 that documented resident experienced short-term memory impairment, long-term memory impairment at times, and memory recall deficit with resident to	S3130		

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S3130	Continued From page 10 spend daytime hours in memory care and return to assisted living apartment after evening meal. The resident log notes contained an entry by a licensed nurse dated 2/10/17 that resident would be dressed and groomed by the assisted living staff in the morning, would then go to memory care unit to participate with meals and activities there, and return to assisted living apartment after the evening meal due to resident's cognition and ability to participate. The record lacked a medical care provider's order and progress notes for this service. During an interview at 4:40 p.m. on 2/17/17, health and wellness director stated he/she did not consult with resident's medical care provider and obtain order for resident to spend daytime hours in memory care unit. The administrator failed to ensure prior to resident #7 spending daytime hours in the memory care unit that the record contained medical care provider's progress notes to justify the time spent in the memory care unit and a written order from a medical care provider for this service,	S3130		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		

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S3155	Continued From page 11	S3155		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(a)

The facility reported a census of 109 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review, interview, and observation for 3 (#1, #7, and #5) of 6 residents sampled, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident. Resident #1 experienced a steady decline in weight from January 2016 through August 2016 when he/she began experiencing pressure related skin breakdown. During the 6 month period from August 2016 through February 2017 the resident experienced at least 4 pressure related wounds and a 15% weight loss with no interventions in place to promote wound healing, prevent further skin breakdown, or address ongoing weight loss.

Findings included:

- Record review for resident #1 revealed an admission date of 12/7/15 and diagnosis of mild cognitive impairment with restlessness and agitation.

The record contained functional capacity screens dated 7/7/16 and 10/24/16 that each indicated resident required physical assistance with transferring, mobility, and toileting; was incontinent of urine; was at risk for falls; and experienced impaired short-term memory, long-term memory, decision making, and memory

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S3155	Continued From page 12	S3155		

recall. The 7/7/16 functional capacity screen indicated resident required physical assistance with eating and the 10/24/16 screen indicated resident was independent with eating.

Negotiated service agreement/health care service plan (NSA/HCSP) dated 7/6/16 and the NSA/HCSP dated 11/10/16 outlined the following services:
Nutrition: resident eats most meals in his/her apartment and will only eat in dining room on occasion.
Showering or bathing: resident is reluctant to shower and has a tendency to yell at and hit staff when attempting to give resident a shower.
Bathroom assistance: Required physical assistance to toilet every 2 to 4 hours during the day and as needed at night. Resident incontinent of urine. Resident frequently refuses care from staff and will not allow staff to change briefs.
Mobility: Uses walker or wheelchair.
Transfer: NSA/HCSP 7/6/16 one-person assistance to transfer and NSA/HCSP 11/10/16 resident required two-person assistance to transfer due to resident unable to bear weight at times.
NSA/HCSP dated 7/6/16 documented resident received hospice services. NSA/HCSP dated 10/24/16 documented resident discharged from hospice 10/11/16. Each NSA/HCSP contained the name of health and wellness director C as the licensed nurse responsible for health care services.

Review of the resident log notes revealed documentation by licensed nurses that resident experienced skin breakdown as follows:

8/31/16 resident has 0.2 centimeter (cm) by 0.2 cm area on right buttock near coccyx. Applied

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S3155	Continued From page 13 cream supplied by hospice. 9/1/16 resident received a gel cushion for chair. 9/20/16 resident's right elbow warm and swollen. Left message for medical care provider to call back. 9/22/16 resident's buttocks very red and tender. Day shift nurse to request barrier cream from hospice. 9/23/16 called medical care provider regarding right arm and elbow. Medical care provider did not call back. 9/26/16 call received back from medical care provider's office and order for hospice nurse to see resident. 10/4/16 hospice order to apply barrier cream to right elbow and to have elbow protector on when in recliner. Note: hospice services discontinued 10/11/16. 10/27/16 has small open area on buttock. Fax sent to medical care provider for dressing to wound. 11/30/16 medical care provider here to see resident and ordered home health services for evaluation and treatment of wound on coccyx. 12/2/16 home health nurse documented for staff to encourage position changes every 2 hours and to rest on either side when in bed. 12/5/16 home health nurse measured stage 2 wound on right buttock at 4cm by 3cm by 0.1 cm	S3155		

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S3155	Continued From page 14 and need to help resident change position every 2 hours while in bed or chair to decrease pressure to wound. 1/1/17 home health here and wound healed. 1/12/17 wound reopened and measured 3.5 cm by 0.4 cm by 0.1 cm. Home health here for wound care. 2/8/17 Resident seen by home health nurse for wound care to right buttock. Wound measures 2.5 cm by 0.5 cm by 0.1 cm. 2/9/17 Resident seen by home health nurse for wound care to right buttock. No dressing was on wound and resident was not sitting on (pressure relieving) cushion. 2/15/17 Home health nurse here for wound care on 2/14/17. The NSA/HCSP lacked interventions for wound healing and prevention of further skin breakdown. NSA/HCSP lacked the services provided by home health. The resident's monthly weight record documented the following: January 2016 135 pounds February 2016 resident refused to be weighed March 2016 130.4 pounds April 2016 128.4 pounds May 2016 128.7 pounds June 2016 no weight recorded July 2016 126.4 pounds August 2016 122.6 pounds September 2016 125.2 pounds October 2016 118.4 pounds November 2016 117 pounds	S3155		

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S3155	Continued From page 15 December 2016 111.2 pounds January 2017 108 pounds February 2017 103.8 pounds The NSA/HCSP lacked interventions to prevent weight loss. Resident's record lacked documentation of medical care provider notification of resident's weight loss. At 1:20 p.m. on 2/16/17 certified staff F stated surveyor could not go into resident ' s apartment to meet resident because resident would scream and become agitated. Certified staff F stated resident did not want people in his/her apartment and resisted care at times. Certified staff F stated we try to toilet resident and provide incontinence care every 2 hours. Certified staff F stated resident had a cushion to relieve pressure when sitting in chair and we try to get resident to rest in bed. Certified staff F confirmed resident had a pressure ulcer and stated home health nurse provided wound care. During an interview at 2:10 p.m. on 2/16/17, health and wellness coordinator E stated he/she was not aware of the resident's weight loss and did not know if another licensed nurse reported the weight loss to the medical care provider. Health and wellness coordinator E stated staff did not monitor resident's food intake when resident ate meals in apartment. When asked for interventions to promote wound healing and prevent further skin breakdown, health and wellness coordinator E stated hospice services in the past and currently home health services for wound care. Health and wellness coordinator E confirmed the resident ' s NSA/HCSP lacked interventions to promote wound healing and to prevent further skin breakdown.	S3155		

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S3155	Continued From page 16 Resident #1 experienced a steady decline in weight from January 2016 through August 2016 when he/she began experiencing pressure related skin breakdown. During the 6 month period from August 2016 through February 2017 the resident experienced at least 4 pressure related wounds and a 15% weight loss with no interventions in place to promote wound healing, prevent further skin breakdown, or address ongoing weight loss. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #1. - Record review for resident #7 revealed an admission date of 8/5/16 and diagnoses of type 2 diabetes mellitus, Alzheimer's disease, and arteriosclerotic heart disease. The record contained a functional capacity screen dated 8/5/16 that indicated resident was independent with toileting, transferring, walking; experienced impaired short-term memory; intact long-term memory, decision making and memory recall; was not at risk for falls; and did not utilize an assistive device for mobility. The record lacked a subsequent functional capacity screen. The record contained a negotiated service agreement/health care service plan (NSA/HCSP) dated 8/5/16 that documented services of facility medication management and physical and occupational therapy provided by an outside resource. Resident was independent with all activities of daily living. This NSA/HCSP documented resident experienced a fall July 2016 during a hospital stay. The NSA/HCSP dated 2/14/17 documented services of physical assistance with toileting; stand-by assistance ambulating with walker; and to be alert for risk for	S3155		

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S3155	Continued From page 17	S3155		

falls. The NSA/HCSP recorded resident's last fall on 2/10/17. NSA/HCSP contained the name of health and wellness director C as the licensed nurse responsible for health care services.

Resident log notes contained documentation by licensed nurses that resident experienced falls:

12/19/16 at 10:45 a.m. witnessed fall in hallway with abrasions to nose and forehead. Left facility for appointment with medical care provider.

12/19/16 2:00 p.m. returned to facility family member reported nose broken and CT (computerized tomography) of head negative.

Note: resident taking blood thinning medications Plavix and aspirin daily.

1/11/17 at 11:00 p.m. resident found lying on floor in hallway. Bruised area above right eye. Transported to hospital emergency department. Admitted to hospital with diagnosis of influenza A.

1/15/17 3:40 p.m. returned to facility and placed on visual check every 2 to 3 hours due to confusion and impulsive behavior.

2/4/17 at 2:00 a.m. staff found resident in apartment on floor leaning against the bathroom door. Multiple skin tears on left elbow.

2/8/17 at 4:35 a.m. staff found resident in apartment on floor on hands and knees. Resident stated he/she hit head. Skin tear to right lower arm and resident complained of pain to head, right shoulder and right elbow. Transported to hospital emergency department.

2/8/17 6:35 a.m. admitted to hospital with

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S3155	Continued From page 18 diagnosis of bradycardia (slow heart rate). 2/10/17 6:10 p.m. returned to facility. 2/10/17 11:37 p.m. at approximately 7:48 p.m. staff found resident on floor of apartment after hearing loud noise from apartment. No injuries noted. 2/14/17 at 3:15 a.m. found on floor of apartment. Resident denied hitting head or in pain. The NSA/HCSP lacked individualized interventions to address the resident's risk for falls. At 1:15 p.m. on 2/16/17, observed resident walking with walker without staff assistance in the hallway of the memory care unit. Resident walked to an exterior door, opened the door and an alarm sounded. Health and wellness coordinator E went to the resident, reset the door alarm, and redirected resident away from the door. At 1:30 p.m. observed resident walk into the dining room and stated he/she was looking for a bathroom. Health and wellness coordinator E assisted resident to the bathroom. At 1:30 p.m. on 2/16/17, certified staff F stated he/she made certain that resident had walker to reduce resident's risk for falling. At 4:40 p.m. on 2/16/17, assistant director of nursing D stated he/she reviewed falls but did not put interventions into place to address resident's risk for falls. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address	S3155		

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S3155	Continued From page 19 resident #7 ' s risk for falls. - Record review for resident #5 revealed an admission date of 8/9/15 and diagnoses of dementia and diabetes mellitus. Functional capacity screen dated 5/11/16 indicated resident was unable to perform toileting, transferring, and mobility; was incontinent of bowel and bladder; experienced impaired short-term memory, long-term memory, decision making, and memory recall and was at risk for falls. Negotiated service agreement/health care service plans (NSA/HCSP) dated 6/21/16 and 11/23/16 each documented services of : Bathroom assistance: toilet every 2 to 4 hours during day and as needed at night. Fall Management Program: resident currently uses a Geri-chair (a mobile recliner for an immobile person). Transfers: Two-person assistance with all transfers. Mobility: resident uses a manual wheelchair as a mobility aid. Each NSA/HCSP contained the name of health and wellness director C as the licensed nurse responsible for health care services. The 6/21/16 NSA/HCSP documented resident received hospice services. The 11/23/16 NSA/HCSP documented resident discharged from hospice 10/19/16. Review of resident log notes by licensed nurses revealed the following: 7/18/16 hospice nurse completed wound care to coccyx that measured 0.5 centimeters (cm) by 0.3 cm with skin macerated around wound.	S3155		

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S3155	Continued From page 20 8/25/16 5:05 p.m. staff informed to transfer resident to bed after meals and elevate resident's feet. Right foot with edema, purple in color and cold to touch. 10/17/16 hospice plans to discharge from services 10/19/16. 12/22/16 coccyx red. Requested and received medical care provider's order for Calmoseptine (ointment to treat minor skin irritation). 12/28/16 medical care provider ordered Tubi-grip (support) stockings and resident to be transferred to bed after meals to elevate lower legs. (Note: to help reduce edema of lower legs and feet.) At 1:25 p.m. on 2/16/17, certified staff F stated resident currently had an area on buttocks that was being treated with an ointment. Certified staff F stated skin care interventions of repositioning resident and use of a cushion on seat of Geri-chair. Note: Resident record lacked documentation of presence of impaired skin integrity on buttocks. At 10:30 a.m. on 2/14/17, observed resident #5 sitting in a Geri-chair with a tray attached to the chair in the resident ' s apartment. At 11:15 a.m. observed a certified employee mobilize resident in Geri-chair into the dining room for meal. At 12:31 p.m. observed certified staff F and certified staff G in the resident ' s apartment transfer resident from Geri-chair to toilet. Certified staff F and certified staff G then transferred resident back to Geri-chair and then to bed. Observed that resident required a pivot transfer and did not take a step by self when transferring.	S3155		

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S3155	Continued From page 21 During an interview at 1:49 p.m. on 2/16/17, health and wellness coordinator E stated resident had an open area on coccyx and waiting on an order for home health to treat wound. Health and wellness coordinator listed skin care interventions as a pressure reducing overlay on mattress, repositioning resident, elevate heels off bed, and use of padded heel protectors. Health and wellness coordinator E confirmed the NSA/HCSP lacked these interventions. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #5.	S3155		
S3260 SS=D	26-41-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and	S3260		

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S3260	Continued From page 22 treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(4)(6) The facility reported a census of 109 residents. The sample included 6 residents and 2 closed records reviewed. Based on record review and interview for 1 (#8) of 2 closed records reviewed, the administrator failed to ensure the record contained the functional capacity screenings and the negotiated service agreements. Findings included: - Closed record review for resident #8 revealed an admission date of 12/28/15 and diagnoses of type 2 diabetes mellitus, chronic obstructive pulmonary disease, and dementia. The record lacked functional capacity screenings and negotiated service agreements. At 11:54 a.m. on 2/16/17, health and wellness director C stated he/she could not locate functional capacity screenings and negotiated service agreements for the resident. The administrator failed to ensure the record of resident #8 contained the functional capacity screenings and the negotiated service	S3260		

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S3260	Continued From page 23 agreements.	S3260		