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	B087137	A. BUILDING: _____ B. WING _____	11/09/2016

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WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for investigation of complaint #105386 of the above home plus facility on 11/2/16, 11/7/16, 11/8/16, and 11/9/16.	S 000		
S5026 SS=J	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1)(B) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 1 (#1) of 3 residents sampled, the operator failed to ensure the resident was not subjected to neglect when a licensed nurse failed to assess the resident and implement medical care provider's hospital discharge orders immediately upon resident's return to the facility. Resident #1 returned to the facility on 10/21/16 following surgery to repair a fractured right hip. Licensed nurse did not implement the medical care provider ' s written orders for medications to reduce the risk of blood clots and infections until 10/24/16 and failed to implement orders for posterior hip precautions to	S5026		

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

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S5026	Continued From page 1	S5026		

prevent dislocation of the surgically repaired hip. These failures placed resident #1 in immediate jeopardy for harm, injury, or death.

Findings included:

- Record review for resident #1 revealed an admission date of 1/11/16 and diagnoses of dementia, cerebral atrophy, and hip fracture.

Facility's record for the resident contained the following documents:

Admission functional capacity screen (FCS)dated 1/11/16 that indicated the resident required supervision with walking/mobility; required physical assistance with bathing, dressing, toileting, and transferring; was unable to perform management of medications and treatments; and experienced impaired short-term memory and memory recall..

Admission negotiated service agreement/health care service plan (NSA/HCSP) dated 1/11/16 documented the facility provided medication management for the resident.

Emergency department documentation 10/17/16 that resident fell yesterday at group home. X-ray showed displaced right sub-capital femoral neck fracture.

Hospital documentation by a medical care provider that resident required right hemiarthroplasty (surgical procedure that replaced one half of the hip joint with a prosthetic, while leaving the other half intact.).

Hospital interagency transfer record that documented hospital admission 10/17/16 and

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hospital discharge 10/21/16 with diagnosis of right hip fracture.

The resident's record lacked documentation of the resident's return from the hospital including an assessment by a licensed nurse.

Resident's record also contained hospital discharge orders dated 10/21/16 that included:

Lovenox (to prevent blood clot formation in deep veins) 30 milligrams subcutaneously daily for 30 days from date of surgery.

Cephalexin (Keflex an antibiotic to treat/prevent infection) 500 milligrams by mouth every 8 hours for 4 days.

Weight bearing as tolerated on right lower extremity and posterior hip precautions (care to keep hip prosthesis from sliding out of position: don ' t bend your hip past a 90 degree angle, don ' t cross your legs, don ' t twist your hip inwards-keep knees and toes pointed upwards)

Staples/sutures right hip incision to be taken out 2 weeks from surgery date if incision healed and no drainage.

Change dressing to right hip if soiled and/or 7 days after application.

Soft, mechanically altered diet.

During an interview at 9:50 a.m. on 11/2/16, when asked for documentation of a licensed nurse assessment of resident when resident returned from hospital 10/21/16, operator B/certified medication aide (CMA) stated (facility nurse) should have assessed the resident. Informed

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operator B/CMA of no assessment documented in resident's record. Operator B/CMA provided a hospice record for the resident and stated to look for documentation in that record.

Review of the hospice nursing documentation revealed the following:

10/21/16 at 4:35 p.m. hospice nurse E documented he/she arrived at facility to check on resident and follow-up with hospital discharge. Resident had not arrived yet and will follow-up 10/22/16.

10/22/16 (no time documented) hospice nurse E documented resident complained of right hip pain and facility staff reported resident had been crying this morning due to right hip pain. Hospice nurse documented he/she administered Roxanol (morphine to treat moderate to severe pain. Note: Roxanol was not reordered by medical care provider on hospital discharge orders. Tylenol 650 milligrams by mouth every 4 hours as needed for pain was ordered.)

10/24/16 (no time documented) hospice nurse D documented resident assessment. Nurse documented he/she faxed medical care provider's orders to pharmacy that included new medications of Lovenox 30 milligrams subcutaneously daily for 30 days (from the date of surgery), Keflex 500 milligrams three times a day for 4 days, bisacodyl (laxative) suppository 10 milligrams every day as needed, and milk of magnesia (laxative) 30 milliliters every day as needed.

Review of the medication administration record dated 10/1/16 through 10/31/16 revealed no documentation of the administration of Lovenox

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injection. The medication administration record contained initials at 8:00 p.m. on 10/24/16 to indicate the first dose of Keflex administered. Operator B/CMA provided a medication administration record dated 10/24/16 through 10/31/16 and stated this was a revised medication administration record sent to facility by the pharmacy. This medication administration record contained initials that indicated the first dose of Lovenox administered at 11:00 a.m. 10/25/16.

During an interview at 10:00 a.m. on 11/2/16, operator B/CMA stated he/she did not know what "posterior hip precautions" were and that he/she just went by physical therapist instructions to move resident slowly and steadily and if resident had difficulty with bearing weight during transfer to use gait belt to help with transfer. Operator B/CMA stated resident did not receive a soft, mechanically altered diet.

During an interview at 12:20 p.m. on 11/2/16, Licensed nurse F stated he/she did not assess the resident after hospital discharge until he/she received a text from facility on 10/24/16 to come assess resident. Licensed nurse F further stated he/she noted hospital discharge orders on 10/24/16 and confirmed resident #1 did not receive Lovenox and Keflex as ordered by medical care provider until 3 days after he/she returned from the hospital. Licensed nurse F confirmed medical care provider ordered hip precautions and mechanical soft diet. Licensed nurse F stated he/she verbally told the certified staff on duty at the time the nurse was in the facility on 10/24/16 what to do for resident such as keep pillow between resident's legs as a hip precaution. Licensed nurse F confirmed he/she did not describe hip precautions in the resident's

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negotiated service agreement/health care service plan to inform all staff members. Licensed nurse F confirmed he/she did not implement the mechanical soft diet order.

Operator B/CMA present during interview at 12:20 p.m. on 11/2/16 and stated resident did return to facility from hospital on 10/21/16 and that he/she informed owner/licensed nurse H of this by text at 5:41 p.m. on 10/21/16. Operator B/CMA confirmed licensed nurse H did not come to the facility to assess resident and note hospital return orders. Operator B/CMA stated he/she administered medications from 10/21/16 through 10/24/16 according to the medication administration record staff followed prior to resident's hospital admission. (Note: the medication administration record CMA/operator B followed on 10/21/16 through 10/24/16 lacked entries for Lovenox 30 milligrams subcutaneously daily for 30 days from date of surgery, Keflex 500 milligrams three times a day for 4 days, bisacodyl suppository 10 milligrams every day as needed, and milk of magnesia 30 milliliters every day as needed.)

During time in the facility on 11/2/16 observed resident sitting in a recliner with feet elevated. Certified staff transferred resident to wheelchair and mobilized resident to dining room table for noon meal. In the afternoon, observed resident sitting in recliner. Resident did not respond when spoken to.

Resident #1 returned from the hospital on 10/21/16 and did not receive ordered medications to reduce the risk for blood clots and infections for 3 days. Staff were providing physical assistance with transfers, mobility and incontinence care and all staff members had not

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S5026	Continued From page 6 been provided instructions regarding posterior hip precautions to reduce the risk of dislocation of the hip prosthesis. The operator failed to ensure the resident was not subjected to neglect when the licensed nurse failed to assess the resident and implement medical care provider's hospital discharge orders immediately upon resident's return to the facility. These failures placed the resident in immediate jeopardy for harm, injury or death. Received the following facility written plan to correct the jeopardy at 4:20 p.m. 11/7/16. " At each admission or transfer from other facility including Hospitals, Rehabs or Behavioral Health units, the expectation will be that the Primary RN (registered nurse) on staff will arrive to the home same day and assess the resident review any transfer paperwork and make or update the care plan and NSA and orders/Mars (medication administration records) as needed. The RN will confer with the operator to notify the operator of any changes that were made and report will be given. Any new nursing staff will be issued the policy and procedure for assessments and medications at hire and will be expected to follow policy. The operator or designated staff member will notify the RN of the admission or return of a resident. The RN will confirm receipt of the notification if it was not verbally exchanged. If the Primary RN is unavailable, the back-up RN will perform the assessment of the resident, review any transfer paperwork and make or update the care plan and NSA and orders/Mars	S5026		

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S5026	Continued From page 7 as needed. The back-up RN will confer with both the operator and the primary RN, upon the RNs return, to notify both individuals of any changes that were made and report will be given. As of 11/7/16 the above described policies and the ongoing expectation of timeliness of assessments and the expectation regarding them has been communicated with the Primary RN and the Licensed Operator of the home. "	S5026		
S5080 SS=E	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(b) The facility reported a census of 5 residents. The	S5080		

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S5080	Continued From page 8	S5080		

sample included 3 residents. Based on record review and interview for 2 (#2 and #3) of 3 residents sampled, the operator failed to ensure a licensed nurse assessed each resident whose functional capacity screening indicated the need for health care services.

Findings included:

- Record review for resident #2 revealed an admission date of 10/11/16 and diagnoses of coronary artery disease, dysphagia, dementia, and anxiety.

The record contained an admission functional capacity screen dated 10/11/16 that indicated the resident required physical assistance with bathing, dressing, and toileting; supervision with transferring and walking; was unable to perform management of medications and treatments; was at risk for falls; and exhibited socially inappropriate disruptive behavior. The functional capacity screen lacked a score for the resident ' s cognitive status. The functional capacity screen lacked the signature of the person who completed the screening.

At 11:55 a.m. on 11/2/16, operator B/certified medication aide stated he/she completed the resident's functional capacity screen and confirmed a licensed nurse did not assess the resident at admission.

The operator failed to ensure a licensed nurse assessed resident #3 whose functional capacity screening indicated the need for health care services.

- Record review for resident #3 revealed an admission date of 10/13/16 and diagnoses of

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S5080	Continued From page 9 Parkinson's disease and dementia. The record contained an admission functional capacity screen dated 10/13/16 that indicated the resident was unable to perform bathing, mobility, and management of medications and treatments; required physical assistance with dressing, toileting, and transferring; and required supervision with eating; was at risk for falls; and exhibited socially inappropriate disruptive behavior. The functional capacity screen lacked a score for the resident ' s cognitive status. The functional capacity screen lacked the signature of the person who completed the screening. At 11:20 a.m. on 11/2/16, operator B/certified medication aide stated he/she completed the functional capacity screen and a licensed nurse did not assess the resident at the time of admission and the functional capacity screen. The operator failed to ensure a licensed nurse assessed resident #3 whose functional capacity screening indicated the need for health care services.	S5080		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant.	S5085		

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S5085	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of 5 residents. Based on record review and interview for 1 (#1) of 3 residents sampled, the licensed nurse failed to conduct a screening to determine the resident's functional capacity following a significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #1 revealed an admission date of 1/11/16 and diagnoses of dementia, cerebral atrophy, and hip fracture. The admission functional capacity screen dated 1/11/16 indicated the resident required supervision with walking/mobility, physical assistance with transferring, and did not have risk for falls. The hospice record contained documentation by hospice nurse C on 10/16/16 that resident experienced a fall and complained of hip pain. On 10/17/16, hospice nurse D documented resident transported to the hospital after an X-ray of right hip showed hip fracture. Hospice nurse E documented on 10/19/16 that resident had surgery 10/18/16 to repair right hip fracture. Hospice nurse E documented resident to return to facility from hospital on 10/21/16. The record contained hospital discharge orders dated 10/21/16 for resident to be weight bearing as tolerated on right lower extremity and posterior hip precautions.	S5085		

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S5085	Continued From page 11 During an interview at 10:00 a.m. on 11/2/16, operator B/certified medication aide stated resident unable to walk and staff used a gait belt for resident to pivot transfer. At 12:20 p.m. on 11/2/16, operator B/certified medication aide stated resident had a significant change in functioning after hospital return and a nurse did not conduct a functional capacity screen. The licensed nurse failed to conduct a screening to determine resident #1's functional capacity following a significant change in condition as defined in K.A.R. 26-39-100.	S5085		
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. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2)	S5116		

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S5116	Continued From page 12 The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 1 (#1) of 3 residents sampled, the operator failed to ensure the revision of resident's negotiated service agreement/health care service plan following a significant change in the resident's condition, as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #1 revealed an admission date of 1/11/16 and diagnoses of dementia, cerebral atrophy, and hip fracture. Resident received hospice service and the hospice record contained documentation by hospice nurse C on 10/16/16 that resident experienced a fall and complained of hip pain. On 10/17/16, hospice nurse D documented resident transported to the hospital after an X-ray of right hip showed hip fracture. Hospice nurse E documented on 10/19/16 that resident had surgery 10/18/16 to repair right hip fracture. Hospice nurse E documented resident to return to facility from hospital on 10/21/16. The record contained hospital discharge orders dated 10/21/16 for resident to be weight bearing as tolerated on right lower extremity, posterior hip precautions, care of surgical incision, and Lovenox (anticoagulant therapy to reduce the risk for deep vein blood clot formation) injection daily for 30 days. On 10/24/16, licensed nurse F (facility nurse) documented in the progress notes that he/she would administer Lovenox 5 days a week and hospice nurse to administer 2 days a week. On 10/27/16 licensed nurse F documented resident to receive home health	S5116		

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S5116	Continued From page 13 services starting 10/29/16 for daily Lovenox injections. Licensed nurse F documented on 10/25/16 resident had red area on coccyx when resident returned from hospital and noted a 1 centimeter open area on left buttock on 10/24/16. Resident's record contained a negotiated service agreement/health care service plan (NSA/HCSP) dated 1/11/16. The NSA/HCSP lacked a revision or amendment to include weight bearing as tolerated right lower extremity, posterior hip precautions, home health services for Lovenox injections, care of surgical incision, measures to heal and prevent further skin breakdown, and interventions to address resident's risk for falls. At 12:20 p.m. on 11/2/16, operator B/certified medication aide stated resident had a significant change in functioning after hospital return and confirmed the lack of revisions to the NSA/HCSP. The operator failed to ensure the revision of resident #1's NSA/HCSP following a significant change in the resident's condition, as defined in K.A.R. 26-39-100.	S5116		
S5117 SS=E	26-42-202 (e) NSA Nurse Participation (e) A licensed nurse shall participate in the development, review, and revision of the negotiated service agreement if the resident's functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by:	S5117		

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WELLSPRINGS OF WICHITA LLC	6311 E MARJORIE ST WICHITA, KS 67208

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S5117	Continued From page 14 KAR 26-42-202(e) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 2 (#2 and #3) of 3 residents sampled, the operator failed to ensure a licensed nurse participated in the development of the negotiated service agreement/health care service plan when the resident's functional capacity screening indicated the need for health care services. Findings included: - Record review for resident #2 revealed an admission date of 10/11/16 and diagnoses of coronary artery disease, dysphagia, dementia, and anxiety. The record contained an admission functional capacity screen dated 10/11/16 that indicated the resident required physical assistance with bathing, dressing, and toileting; supervision with transferring and walking; was unable to perform management of medications and treatments; was at risk for falls; and exhibited socially inappropriate disruptive behavior. The negotiated service agreement/health care service plan (NSA/HCSP) signed by operator B and resident's durable power of attorney for health care on 10/11/16 documented facility to provide health care services of physical assistance with dressing, toileting, transferring, walking, and management of medications. The NSA/HCSP lacked the signature of a licensed nurse to indicate licensed nurse participation in the development of the agreement. At 11:55 a.m. on 11/2/16, operator B/certified	S5117		

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S5117	Continued From page 15 medication aide confirmed a licensed nurse did not participate in the development of the resident's NSA/HCSP. The operator failed to ensure a licensed nurse participated in the development of the NSA/HCSP when resident #2's functional capacity screening indicated the need for health care services. - Record review for resident #3 revealed an admission date of 10/13/16 and diagnoses of Parkinson's disease and dementia. The record contained an admission functional capacity screen dated 10/13/16 that indicated the resident was unable to perform bathing, mobility, and management of medications and treatments; required physical assistance with dressing, toileting, and transferring; and required supervision with eating; was at risk for falls; and exhibited socially inappropriate disruptive behavior. The negotiated service agreement/health care service plan (NSA/HCSP) signed by operator B/certified medication aide and resident's family member on 10/13/16 documented facility provided health care services of physical assistance with dressing, toileting, incontinence care, transferring, mobility, grooming, and management of medications. At 11:20 a.m. on 11/2/16, operator B/certified medication aide confirmed a licensed nurse did not participate in the development of the NSA/HCSP. The operator failed to ensure a licensed nurse participated in the development of the NSA/HCSP	S5117		

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S5117	Continued From page 16 when resident #3's functional capacity screening indicated the need for health care services.	S5117		
S5161 SS=E	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 3 (#1, #2, and #3) of 3 residents sampled, the operator failed to ensure each resident's negotiated service agreement/health care service plan contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. Findings included: - Record review for resident #1 revealed an admission date of 1/11/16 and diagnoses of dementia, cerebral atrophy, and hip fracture. Resident's record contained a negotiated service agreement/health care service plan (NSA/HCSP) dated 1/11/16. The NSA/HCSP contained a description of health care services for assistance with bathing, dressing, toileting, transferring, and management of medications. The NSA/HCSP contained the name of licensed nurse G as the	S5161		

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S5161	Continued From page 17	S5161		

nurse responsible for the implementation and supervision of the health care service plan.

During an interview at 12:00 p.m. on 11/2/16, operator B/certified medication aide stated licensed nurse G was no longer employed at the facility as of 8/12/16.

The operator failed to ensure resident #1's NSA/HCSP contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.

- Record review for resident #2 revealed an admission date of 10/11/16 and diagnoses of coronary artery disease, dysphagia, dementia, and anxiety.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 10/11/16 documented facility to provide health care services of physical assistance with dressing, toileting, transferring, walking, and management of medications. The NSA/HCSP lacked the name of the nurse responsible for the implementation and supervision of the health care service plan.

The operator failed to ensure resident #2's NSA/HCSP contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.

- Record review for resident #3 revealed an admission date of 10/13/16 and diagnoses of Parkinson's disease and dementia.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 10/13/16 documented facility provided health care services of physical assistance with dressing, toileting,

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S5161	Continued From page 18 incontinence care, transferring, mobility, grooming, and management of medications. The NSA/HCSP lacked the name of the nurse responsible for the implementation and supervision of the health care service plan. The operator failed to ensure resident #3's NSA/HCSP contained the name of the licensed nurse responsible for the implementation and supervision of the health care service plan.	S5161		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 1 (#1) of 3 residents sampled, the operator failed to ensure health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice. Findings included: - Review of the resident roster revealed resident #1 experienced a fall within the last 180 days. Record review for resident #1 revealed an admission date of 1/11/16 and diagnoses of dementia, cerebral atrophy, and hip fracture.	S5171		

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S5171	Continued From page 19 The functional capacity screen dated 1/11/16 indicated the resident was independent with eating; required supervision with walking/mobility; required physical assistance with bathing, dressing, toileting, and transferring; was unable to perform management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory and memory recall; and utilized a walker and wheelchair as assistive devices for mobility. The record contained a radiology report dated 10/17/16 that documented resident had right hip pain after a fall and x-ray showed fractured femur neck. Emergency department documentation 10/17/16 that resident fell yesterday at group home. X-ray showed displaced right sub capital femoral neck fracture. The resident's record lacked documentation by a licensed nurse of the resident's fall During an interview at 9:50 a.m. on 11/2/16, when asked for documentation of resident's fall and the licensed nurse assessment of resident, operator B/certified medication aide (CMA) provided a hospice record for the resident and stated to look for documentation in that record. Review of the hospice nursing documentation revealed the following: 10/16/16 (no time documented) Hospice nurse C documented (resident) "sitting in a chair awake. Had a fall tonight. Is c/o (complaining of) pain in RT (right) hip/leg. No signs of hip fracture." Hospice nurse documented resident's family	S5171		

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S5171	Continued From page 20	S5171		

member notified and wants to wait until morning to re-evaluate resident.

10/17/16 (no time documented) hospice nurse D documented resident was resting in a recliner, complained of right hip pain, and rated pain as 10 with 10 being "hurts worst." Hospice nurse notified resident's medical care provider and received new order and awaiting X-ray reports.

10/17/16 at 2:10 p.m. hospice nurse E documented right hip X-ray shows right femoral neck fracture.

At 2:20 p.m. on 11/2/16, operator B/CMA stated he/she was informed by (certified staff J) that resident stood up from recliner in the living room and fell after the evening meal on 10/16/16.

Telephone interview with certified staff J at 5:50 p.m. on 11/2/16. Certified staff J stated he/she was in living room and heard resident fall. Certified staff J stated he/she obtained resident's vital signs and called the hospice nurse. Certified staff J stated he/she and the other certified staff on duty transferred resident from the floor to the recliner prior to hospice nurse's arrival. Certified staff J stated the hospice nurse did not tell certified staff not to move resident from the floor after the fall until the nurse assessed the resident.

Resident #1 experienced a fall that resulted in right hip fracture. Certified staff transferred resident from the floor prior to an assessment by a licensed nurse. The operator failed to ensure health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice.

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S5300	Continued From page 21	S5300		
S5300 SS=E	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 5 residents. The sample included 3 residents. Based on record review and interview for 2 (#1 and #2) of 3 residents sampled, the operator failed to ensure that medications were administered in accordance with a medical care provider's written order. Findings included: - Record review for resident #1 revealed an admission date of 1/11/16 and diagnoses of dementia, cerebral atrophy, and hip fracture.	S5300		

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S5300	Continued From page 22 The admission functional capacity screen dated 1/11/16 indicated the resident was unable to perform management of medications. The negotiated service agreement/health care service plan dated 1/11/16 documented medications administered by certified/licensed staff. The record contained medical care provider's orders dated 10/21/16 when resident was dismissed from hospital that included new medications of Lovenox (to prevent blood clot formation in deep veins) 30 milligrams subcutaneously daily for 30 days from date of surgery and cephalexin (Keflex an antibiotic to treat/prevent infection) 500 milligrams by mouth every 8 hours for 4 days. Review of the medication administration records revealed resident did not receive Lovenox injection on 10/22/16, 10/23/16, and 10/24/16 and did not receive cephalexin on 10/22/16, 10/23/16, missed 2 doses on 10/24/16. The medication administration record contained documentation resident received Roxanol (morphine to treat moderate to severe pain) 10/22/16. The medical care provider did not reorder Roxanol after hospital discharge. During an interview at 12:20 p.m. on 11/2/16, licensed nurse F confirmed resident #1 did not receive Lovenox and Keflex as ordered by medical care provider. The operator failed to ensure that medications were administered to resident #1 in accordance with a medical care provider's written order. - Record review for resident #2 revealed an admission date of 10/11/16 and diagnoses of	S5300		

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S5300	Continued From page 23 coronary artery disease, dysphagia, dementia, and anxiety. The record contained an admission functional capacity screen dated 10/11/16 that indicated the resident was unable to perform management of medications. The negotiated service agreement/health care service plan dated 10/11/16 through 10/31/16 documented medications administered by certified/licensed staff. Review of the 10/1/16 medication administration record revealed certified medication aides administered the following medications to resident #2: Aspirin (anticoagulant) 325 milligrams 1 tablet by mouth every other day. Atorvastatin 40 milligrams 1 tablet by mouth for increased cholesterol. Carvedilol 3.125 milligrams 1 tablet by mouth daily for hypertension. Clopidogrel (anti-coagulant)75 milligrams 1 tablet by mouth daily. Remeron 15 milligrams by mouth at bedtime for insomnia. Furosemide 40 milligrams 1 tablet daily for edema. Magnesium oxide (supplement) 400 milligrams 1 tablet by mouth daily. Potassium Chloride (supplement) 20 mill	S5300		

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S5300	Continued From page 24 equivalents 1 tablet by mouth daily. Tamulosin (to improve urine flow) 0.4 milligram 1 capsule by mouth daily. Haloperidol 1 milligram 1 tablet by mouth 2 times a day for agitation. Zyprexa 7.5 milligrams by mouth at bedtime for agitation. Hydrocodone (pain relief) 5/325 milligrams 1 tablet by mouth 3 times a day for pain. The record lacked medical care provider's written order for these medications. At 12:45 p.m. on 11/2/16, operator B/certified medication aide confirmed the resident's record and hospice record lacked the medical care provider's written order for medications. The operator failed to ensure that medications were administered to resident #2 in accordance with a medical care provider's written order.	S5300		