STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087184	A. BUILDING: _____ B. WING _____	06/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HOME	1425 N STRATFORD LN WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated (complaint) survey at the above named facility on 6/6/16, 6/7/16, 6/8/16, 6/9/16 and 6/13/16.	S 000		
S5170 SS=D	26-42-204 (g) (h) Health Care Services (g) Skilled nursing care shall be provided in accordance with K.S.A. 39-923 and amendments thereto. (1) The health care service plan shall include the skilled nursing care to be provided and the name of the licensed nurse or agency responsible for providing each service. (2) The licensed nurse providing the skilled nursing care shall document the service and the outcome of the service in the resident ' s record. (3) A medical care provider ' s order for skilled nursing care shall be documented in the resident ' s record in the home. A copy of the medical care provider ' s order from a home health agency or hospice may be used. (4) The administrator or operator shall ensure that a licensed nurse is available to meet each resident ' s unscheduled needs related to skilled nursing services. (h) A licensed nurse may provide wellness and health monitoring as specified in the resident ' s negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(g)(2) The facility identified a census of 8 residents. The sample included 3 residents. Based on record review and interview for 1 (#5) of 3 residents sampled, the operator/Licensed	S5170		

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

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S5170	Continued From page 1 Practical Nurse (LPN) failed to ensure the licensed nurse providing the skilled nursing care shall document the service and the outcome of the service in the resident's record. Findings included: - Record review for resident #5 revealed an admit date of 2-25-16 with diagnoses of dementia with lewy bodies, parkinson's, hypertension, depression, and rheumatoid arthritis. The functional capacity screen 5-2-16 recorded resident unable to assist with bathing, dressing, toileting, transfer, required physical assistance with walking/mobility, eating, occasional incontinence, experienced falls/unsteadiness, impaired hearing, and short term memory loss, memory/recall, and impaired decision making. The negotiated service agreement/health care plan (NSA/HCP) dated 5-2-16 recorded resident to have a tab alarm while in bed, use walker or wheelchair, physical assist of one with walker short distance, weight bearing as tolerated, physical assist of one for shower, wears depends as incontinent of bowel and bladder, physical assist with dressing, LPN/Certified Medication Aide (CMA) to manage treatments, home health for physical therapy and for wound care to incision, hip precautions when turning in bed: Hip precautions while turning resident in bed or changing resident: 1. Gather all supplies 2. Keep wedge between knees when turning resident 3. Roll resident on non-surgical side, ensuring no adduction (moving limb toward the midline of body).	S5170		

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S5170	Continued From page 2 Resident Service Notes recorded: 4-21-16 at 8:30 p.m. X-ray results faxed to facility. Impression: Fracture of the right hip femoral neck. 4-28-16 at 2:30 p.m. resident sent to hospital per facility staff. 5-2-16 at 4:40 p.m. "Resident returned to facility. Resident alert, oriented to self, disoriented to place. States right hip, "sore" dressing to right hip intact/dry. . . Home health to be out tomorrow to evaluate skin care to coccyx, physical therapy and occupational therapy ordered." 5-3-16 at 10:00 a.m. Home health out to evaluate resident. 5-3-16 at 10:00 p.m. Resident able to bear partial weight. 5-5-16 at 10:00 p.m. Resident refused supper, complained of right hip pain. . 5-19-16 at 1:00 p.m. " Resident out of facility per private auto accompanied by staff to physician ' s office for check up on right hip. Incision site has a two inch by one inch black area, very small amount of blood draining (hematoma). 5-25-16 at 11:30 a.m. " Due to increase odor and draining of incision, home health nurse contacted the orthopedic physician for orders. New orders for Bactrim two times a day for fourteen days and to see physician on 5-26-16 at 11:15 a.m. " 5-26-16 at 12:30 p.m. Resident returned to facility (from appointment with orthopedic physician) with orders for resident to see a plastic surgeon on 6-1-16 due to skin dying around incision site, may have to scrape and clean out wound, then use wound vac with worst case scenario would be a skin graft. 6-1-16 at 4:00 p.m. went to physician office regarding incision infection. . . . New order to	S5170		

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S5170	Continued From page 3	S5170		

apply dry dressing to incision site daily and reapply if it becomes loose or falls off. Home health notified of new orders.
6-1-16 at 10:30 p.m. hospital notified to inform resident to be admitted on 6-2-16 in the morning to do an incision and drainage (I and D) of right hip on 6-3-16.
6-2-16 at 10:30 a.m. resident admitted to hospital.
6-3-16 at 4:00 p.m. hospital called and stated surgery went well and resident will be getting a skin graft in about a week. Expect resident to be gone two to three weeks.

No further documentation in the Resident Service Notes.

Admission skin assessment drawing dated 2-25-16 at 6:30 p.m. (should be dated 5-2-16) identified resident had a heparin lock in left arm and a dry dressing intact on right hip signed by operator/LPN.

The record contained an office note from the orthopedic dated 5-19-16 that recorded the following:
Diagnosis: Displaced fracture of base of neck of right femur, subsequent encounter for closed fracture.

Comments: Patient needs wound check to right hip every two days. Call us with worsening drainage or worsening appearance of the wound.

The resident record contained one home health visit from the nurse dated 6-1-16 that recorded: Right hip incision continues to have small amount serosangineous drainage. Edges continue to be slightly red. Patient has scheduled follow up appointment with doctor today to evaluate incision. Patient had minimal verbal interaction

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S5170	Continued From page 4 today. Mostly mumbling. The record lacked documentation of dressing changes as ordered and a description of the wound at each dressing change with any follow up action taken. Written statement from operator/LPN on 6-7-16 at 4:00 p.m. stated " home health provided wound care to resident. (Operator/LPN) did see wound on 5-26-16 and no notes made by me due to resident had home health nurse. I called the home health agency on 6-6-16 to have them fax any documentation and only note faxed was from visit on 6-1-16. " The operator/LPN confirmed the record lacked documentation of assessment of wound and any dressing changes provided. Interview on 6-7-16 at 3:30 p.m. with operator/LPN stated received a phone call from the hospital to be informed resident had surgery with wound vac applied. The resident crossed legs and the nurses heard a loud pop and resident ' s hip was dislocated again. For resident #5, the operator/LPN failed to ensure the licensed nurse providing the skilled nursing care shall document the service and the outcome of the service in the resident's record.	S5170		
S5255 SS=D	26-42-102 (a) Staff Qualifications Sufficent Staff (a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of qualified personnel to provide each resident with services and care in accordance with that resident ' s functional capacity screening, health care service plan, and negotiated service agreement.	S5255		

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S5255	Continued From page 5 This REQUIREMENT is not met as evidenced by: KAR 26-42-102(a) The facility identified a census of 8 residents. The sample included 3 residents. Based on record review, interviews, and observations for 1 (#4) of 3 residents sampled, the operator failed to ensure the provision of a sufficient number of qualified personnel to provide resident with services and care in accordance with the Functional Capacity Screen (FCS), Health Care Plan (HCP) and Negotiated Service Agreement (NSA). Findings revealed: - Record review for resident #4 revealed an admit date of 3-18-13 with diagnoses of osteoporosis, heart failure, hypertension, dementia, and fractured left hip on 3-29-16. The FCS dated 3-13-16 recorded resident required physical assistance with transfer, walking/mobility, bladder incontinence, unable to assist with toileting, experienced impaired short term memory, memory recall, long term memory, and decision making. The NSA/HCP dated 3-16-16 included certified staff/licensed nurse to administer medications/treatments, resident is combative with behaviors, required one on one staff assist at times, ambulates by self with walker and supervision, one staff assist with incontinent care, dressing, Resident alert but confused, hourly checks for fall prevention. Resident service notes recorded resident #4	S5255		

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S5255	Continued From page 6	S5255		

experienced a fall on 5-29-16 that resulted in a left hip fracture that was surgically repaired on 5-30-16.

The resident service notes further recorded:

6-2-16 at 4:00 p.m., Resident returned to facility and complained of left hip pain. Resident alert and oriented to self. Disoriented to time and place. " Left outer hip has dressing over staples/sutures, right inner thigh has eight by 3 inch red bruise. . .Resident can have weight bearing as tolerated. . . .

6-2-16 at 10:00 p.m., Resident crying/screaming during care noted after resident returned at 4:00 p.m. Able to transfer from seat to wheel chair with one person assist without difficulties.

6-3-16 at 7:00 p.m., Resident ate 80% of dinner. Resident drinks better after 8:00 p.m. medications. Will encourage fluids then.

The record lacked further documentation.

Interview on 6-6-16 at 12:00 noon with Operator/LPN stated and confirmed he/she had not completed a significant change FCS or amended/completed a NSA/HCP.

On 6-7-16 at 1:55 p.m., the Operator/LPN provided a FCS dated 6-6-16 that recorded the following: Resident is unable to assist with bathing dressing, toileting, transfer, medications, management of treatments, required physical assistance with walking/mobility, eating, incontinent of bladder control, experienced short term memory loss, long term memory loss, memory recall, decision making, at risk for

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S5255	Continued From page 7	S5255		

falls/unsteadiness, and impaired decision making.

The NSA/HCP dated 6-6-16 included the following: Resident required one to two person assist with ambulating with walker short distance, two person assist to transfer. . . Two person assist in bathroom toilet, wears depends, hip precautions, one person assist while in bed. Tab alarm when in bed. Physical therapy.

Hip Precautions: 1.) gather all supplies. 2.) Keep two pillows between knees when turning resident. 3.) Roll resident on non-surgical side ensuring no adduction.

Interview on 6-6-16 at 10:40 a.m. with CMA #C stated (resident #4) is a two person assist and confirmed only had one certified staff on from 9:30 p.m. to 6:00 a.m.

On 6-6-16 at 11:30 a.m., observed the physical therapist and certified staff #A assist resident #4 up from recliner with gait belt and two person assist. Resident yelling out in pain and pushing self away from certified staff #A and physical therapist. The physical therapist stated resident is a two person transfer at this time.

On 6-6-16 at 1:15 p.m. observed CMA #C and certified staff #A transfer resident #4 from wheel chair to bed with use of gait belt and two person assist. Resident screamed/yelled out as if in pain with movement.

Interviews with certified staff #F 6-6-16 at 9:20 p.m., with certified staff #A 6-7-16 at 2:25 p.m. both stated resident #4 is a two person transfer.

Written statement provided on 6-6-16 at 12:00 noon from Operator/LPN recorded (resident #4)

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S5255	Continued From page 8 is a two person transfer for toileting. Certified staff on duty from 9:30 p.m. to 6:00 a.m. are to call him/her to come and assist when two staff required to provide care to resident. It will take him/her ten minutes to get to facility from home. Interviews with CMA #E on 6-6-16 at 9:10 p.m., CMA #D on 6-7-16 at 2;25 p.m. and CMA #B on 6-7-16 at 2:40 p.m., all stated resident #4 is a two person transfer and only one staff is scheduled on duty from 9:30 p.m. to 6:00 a.m. each day. If resident #4 needs to transfer or toilet, staff have been instructed to call Operator/LPN to come to facility from home and assist. For resident #4, the operator failed to ensure the provision of a sufficient number of qualified personnel to provide resident with services and care in accordance with the FCS, Health HCP and NSA when only 1 staff scheduled on duty for over 8 hours each day with a resident who requires the assist of 2 staff to transfer and toilet.	S5255		