STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087167	A. BUILDING: _____ B. WING _____	R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER RD WICHITA, KS 67212

(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 special revisit of the above home plus facility on 1-21-16, 1-25-16, 1-27-16, and 1-28-16.	{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 identified a census of 7 residents. The sample included 3 residents. Based on record review, interview, and observations for 1 (#3333) of 3 residents sampled, the Owner/Operator/Registered Nurse (RN) failed to provide service reasonably necessary to ensure safety and well-being and avoid physical harm or illness. Resident #3333 experienced a seizure lasting 8 - 10 minutes, with bleeding noted from mouth and the owner/operator/RN failed to complete an assessment of the resident, notify the medical care provider immediately and further failed to complete follow up assessment or notify the medical care provider until approximately 2 hours later when the resident could not be aroused. These failures placed the resident in	S5026		

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

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S5026	Continued From page 1	S5026		

immediate jeopardy of harm, injury or death. Findings included:

- Record review for resident #3333 revealed an admit date of 1-31-15 with diagnoses of osteoporosis, hypertension, cerebral vascular accident with left sided paralysis.

The functional capacity screen dated 1-31-15 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, unable to manage medications/treatments, frequently incontinent, usually understandable, experienced impaired decision making and impaired hearing.

The negotiated service agreement (NSA)/health care service plan (HCSP) dated 1-31-15 and amended on 8-31-15 recorded staff assist with toileting, resident will be repositioned every two hours while in bed and every one hour when up in chair due to left sided paralysis, provide mechanical soft diet with pudding thickened liquids.

Progress notes recorded the following: (No date, no time), "Operator/Owner/RN, family members, and certified staff C were present in resident's room while certified staff C was finishing bed bath when resident began what appeared to be a ' classic tonic clonic seizure. ' Family member confirmed that resident had a seizure approximately ten years ago. . . This seizure appeared to last several minutes. Blood began coming out of left side of residents lips and I knew that resident had most likely bitten tongue. Finally, the seizing stopped and resident slept. I spoke with the family and explained that after that type of seizure, resident would most likely sleep for a while. Family stayed for approximately thirty

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S5026	Continued From page 2 more minutes and then left." There was no further documentation in the progress notes. The record lacked documentation of assessment of mouth and tongue related to bleeding, documentation of vital signs taken following the seizure, and follow up assessment of the resident after the seizure. 1-25-16 at 10:35 a.m. Operator/Owner/RN stated, resident #3333 had a seizure while Certified staff C was giving a bed bath. Stated he/she went in to tell certified staff #C not to wash feet and further stated the family was present during the seizure. He/she stated " I did not have a watch and think the seizure lasted approximately 4 minutes. Resident had blood coming from mouth and may have bitten tongue. " Operator/owner/RN further stated he she " took vital signs using pulse oximeter for oxygen saturation and pulse, used blood pressure cuff for blood pressure. Vital signs normal. " Further stated he/she " stayed with resident #3333 for a little while and watched him/her breath. The family stayed for thirty minutes after resident was sleeping. I was not concerned at all until (resident) did not wake up; a family member came to visit and I went to room to introduce self and Resident could not wake up. Noted strong pulse. Had certified staff #C come back to help sit resident up. Resident ' s eyes came open when was sat on side of bed but kept looking down like he/she was not there. At 5:23 p.m. called medical care provider who stated to call 911. EMS notified and left facility with resident at 5:50 p.m. The Operator/Owner/RN further stated and confirmed he/she did not document the seizure or notify medical care provider until approximately two hours after the seizure."	S5026		

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S5026	Continued From page 3 Operator/Owner/RN confirmed resident #3333 did not have a seizure diagnosis and confirmed that vital signs taken during or following the seizure were not documented anywhere. Certified staff #C was not available for interview and phone number provided to reach him/her was no longer in service. The hospital history and physical dated 1-22-16 recorded, "today at approximately 3:00 p.m. with family present, (resident) noted to have generalized tremors all over body with apparent seizure. This lasted approximately five to eight minutes and aborted spontaneously. . . Unfortunately, at the event today, they did not seek any medical care initially and let (resident) rest afterwards. At 5:00 p.m., however, they were unable to wake (resident) up and subsequently felt (resident) had facial droop and brought him/her to emergency department. . . was admitted to the medical Intensive Care Unit (ICU) due to severity of the event and concern for seizure. Resident was given Keppra (for seizures) 500 milligrams (MG) Intravenously (IV). Since arrival to ICU, the (resident) is admitted essentially nonverbal. ASSESSMENT AND PLAN: 1. (Resident) came to ER in a postictal state [altered state of consciousness after a seizure usually lasting between 5 and 30 minutes but may be longer in case of more severe seizure] after seizure episode. At this point, will start Keppra 500 MG two times daily. . the risk of seizures would outweigh the risk of medications. We will continue to monitor in the ICU on telemetry to make sure electrolytes are in normal range. 2. Questionable stroke. The (resident) has history of stroke in the past and has a history of right basal ganglia hemorrhage as well. For now, I would like to see how (resident) responds	S5026		

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S5026	Continued From page 4 initially to get out of the postictal state. We will not pursue any aggressive intervention. The DNR order will be honored." Interview on 1-25-16 at 3:05 p.m. with family member stated (resident) would not wake up after a seizure and may of had a stroke (on 1-22-16). Stated was present when resident had the seizure that lasted eight to ten minutes. Operator/Owner/RN stated the family could go home after forty-five minutes because (resident) was going to sleep for a while since having the seizure. About 5:45 p.m., Operator/Owner/RN called and stated (resident) was not responding and unable to wake up, doctor called and instructed to call 911. EMS on way to get resident. Family member arrived in time to ride in ambulance with (resident) to hospital at approximately 6:00 p.m.. Today (1-25-16) resident still not waking up or responding as did prior to seizure. For resident #3333, the Owner/Operator/RN failed to provide service reasonably necessary to ensure safety and well-being and avoid physical harm or illness. Resident #3333 experienced a seizure lasting 8 - 10 minutes, with bleeding noted from mouth and the owner/operator/RN failed to complete an assessment of the resident, notify the medical care provider immediately and further failed to complete follow up assessment or notify the medical care provider until approximately 2 hours later when the resident could not be aroused. These failures placed the resident in immediate jeopardy of harm, injury or death. The immediate jeopardy was removed when resident was transferred to hospital.	S5026		

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{S5155}	Continued From page 5	{S5155}		
{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) The facility identified a census of 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 2 (#3333 and #3335) of 3 residents sampled, the owner/operator/registered nurse (RN) failed to provide or coordinate necessary health care services. Findings included: - Record review for resident #3333 revealed an admit date of 1-31-15 with diagnoses of osteoporosis, hypertension, cerebral vascular accident with left sided paralysis. The functional capacity screen dated 1-31-15 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, unable to manage medications/treatments, frequently incontinent, usually understandable, experienced impaired decision making and impaired hearing.	{S5155}		

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{S5155}	Continued From page 6 The negotiated service agreement (NSA)/health care service plan (HCSP) dated 1-31-15 and amended on 8-31-15 recorded resident received a shower two times a week, staff assist with dressing and undressing resident, staff assist with toileting, resident will be repositioned every two hours while in bed and every one hour when up in chair due to left sided paralysis, provide mechanical soft diet with pudding thickened liquids, certified medical staff and licensed staff will administer medications and treatments as ordered by medical care provider. The progress notes recorded the following: 11-20-15 10:00 a.m., Received an order from medical care provider for Cipro 250 Milligrams (MG) two times a day for 10 days from results of urinalysis test/culture. The medical care provider also ordered resident to get a PICC line placement for intravenous vancomycin (antibiotic). Medical care provider ordered resident be admitted to a skilled facility since unable to get PICC line placement while in current facility. Resident transferred to a skilled facility. On 11-22-15. 12-9-15 at 3:30 p.m., "Resident returned from skilled facility. Upon arrival, observed a wound on coccyx and two more down lower 'closer to buttocks area'. Upon examination, a large round pressure wound was found on left calcaneus (heel) as well as three small wounds on big toe, 2nd toe, and 3rd toe. Right foot had a small wound on heel, but not as bad as wound on left foot. Sent a picture to medical care provider. Orders given for care and comfort. Provalon boot was bought for left heel and place on heel for protection. Medihoney was placed on coccyx	{S5155}		

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{S5155}	Continued From page 7	{S5155}		

area. Right calcaneus wound was size of quarter; left calcaneus wound was size of fifty-cent piece. All foot wounds are dark brown to blackish in color. Sacrum and coccyx wound are peeling, red, and have raw looking areas on them. Will continue to monitor all wounds."

No further documentation in progress notes.

Interview on 1-21-16 at 1:45 p.m. with Operator/Owner/RN stated and confirmed, "Did not identify wound care in the Negotiated Service Agreement (NSA)/Health Care Service Plan (HCSP) or in-service staff on pressure/ulcer or wound care."

On 1-21-15 at 2:20 p.m., Operator/Owner/RN and surveyor observed resident #3333's wounds on feet. Right foot heel revealed a black closed wound measuring 3.5 Centimeter (CM) by 4.5 CM. Left foot inner heel revealed a black closed wound the size of a nickel.

On 1-21-16 at 2:45 p.m., Operator/Owner/RN stated and confirmed he/she had no orders for treatment of pressure ulcers on right and left heels.

The Owner/Operator/RN failed to provide or coordinate necessary health care services for resident for pressure ulcers on feet.

- At 10:15 a.m. on 1-21-16, observed resident #3335 in recliner with family member at side. Resident #3335 skin color pale. Certified staff #A stated resident "is getting ready to pass."

Record review for resident #3335 revealed an admission date of 7-1-11 and diagnoses of

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{S5155}	Continued From page 8 Parkinson's disease and Alzheimer's dementia. The functional capacity screen dated 8-16-15 indicated the resident was unable to perform bathing, dressing, toileting, transferring, and management of medications and treatments; was unable to feed self; required physical assistance for mobility; was frequently incontinent of urine; experienced impaired cognition; impaired ability to communicate and understand communication; was at risk for falls; required a wheelchair for mobility and a mechanical lift for transfers. The negotiated service agreement/health care service plan dated 8-16-15 documented facility staff provided physical assistance with bathing, dressing, toileting, and mobility per wheelchair; transfer assistance of one person using mechanical lift or two-person transfer assistance; feeding assistance; and administration of medications and treatments. The record contained a medical care provider's order dated 1-8-16 to transport resident to emergency room per emergency medical services due to hemoptysis (the coughing up of blood), diaphoresis, and decreased level of consciousness. The Owner/Operator/RN documented in the progress notes on 1-8-16 that he/she received call from staff person to report resident was not responding, blood pressure 96/38, pulse 76, and oxygen saturation 96%. Medical care provider ordered transport to emergency room per emergency medical services due to hemoptysis. The record lacked documentation that resident returned from the emergency room on 1-8-16.	{S5155}		

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{S5155}	Continued From page 9 At 11:10 a.m. on 1-21-16, Owner/Operator/RN stated resident returned to the facility on 1-8-16 and after medical care provider reviewed laboratory results, the medical care provider instructed the resident to be admitted to the hospital for gastrointestinal bleed. Owner/Operator/RN stated resident returned to the facility after spending one night in the hospital and staff began providing comfort care measures to the resident. Further review of the resident's negotiated service agreement/health care service plan revealed the lack of comfort care measures staff were to provide for the resident. At 11:30 a.m. on 1-21-16, Owner/Operator/RN stated he/she did not revise the resident ' s negotiated service agreement/health care service plan to include a description of comfort care measures. The Operator/Owner/RN stated he/she did not have a policy and procedure to outline comfort care measures. The Owner/Operator/RN failed to provide or coordinate necessary health care services for resident #3335.	{S5155}		
{S5185} SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened	{S5185}		

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{S5185}	Continued From page 10 consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility identified a census of 7 residents. The sample included 3 residents. Based on interview, record review, and observation for 1 (#3333) of 3 residents sampled, the owner/operator/registered nurse (RN) failed to ensure the provision of thickened liquids prepared according to written instructions from a medical care provider. Findings included: - At 10:15 a.m. on 1-21-16, certified staff #A stated (resident #3333) required thickened liquids. At 10:20 a.m. on 1-21-16, certified staff #B provided written instructions for thickening liquids. The instructions lacked the signature of a medical provider or licensed dietitian. Record review for resident #3333 revealed an admission date of 1-31-15 and diagnoses of cerebral vascular accident with left side hemiparesis, hypertension, and osteoporosis. The functional capacity screen dated 1-31-15 indicated the resident required physical	{S5185}		

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{S5185}	Continued From page 11 assistance with eating. The negotiated service agreement/health care service plan dated 9-16-15 documented resident to receive a mechanical soft diet and pudding thick liquids. At 11:25 a.m. on 1-21-16, owner/operator/RN instructions for thickening liquids. Owner/operator/RN confirmed the instructions lacked the signature of the medical care provider or licensed dietitian. For resident #3333, the owner/operator/RN failed to ensure the provision of thickened liquids prepared according to written instructions from a medical care provider.	{S5185}		
{S5251} SS=E	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 identified a census of 7 residents. The sample included 3 residents. Based on record review, observation, and interview for 3 (#3333, #3335, and #3337) of 3 residents sampled, the owner/operator/registered nurse (RN) failed to ensure each resident's record contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence,	{S5251}		

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{S5251}	Continued From page 12	{S5251}		

action taken, and results of the action.

Findings including:

- Record review for resident #3333 revealed an admit date of 1-31-15 with diagnoses of osteoporosis, hypertension, cerebral vascular accident with left sided paralysis.

The functional capacity screen dated 1-31-15 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, eating, unable to manage medications/treatments, frequently incontinent, usually understandable, experienced impaired decision making and impaired hearing.

The negotiated service agreement (NSA)/health care service plan (HCSP) dated 1-31-15 and amended on 8-31-15 recorded resident received a shower two times a week, staff assist with dressing and undressing resident, staff assist with toileting, resident will be repositioned every two hours while in bed and every one hour when up in chair due to left sided paralysis, provide mechanical soft diet with pudding thickened liquids, certified medical staff and licensed staff will administer medications and treatments as ordered by medical care provider.

The progress notes recorded the following:

12-9-15 at 3:30 p.m., "Resident returned from skilled facility. Upon arrival, observed a wound on coccyx and two more down lower 'closer to buttocks area'. Upon examination, a large round pressure wound was found on left calcaneus (heel) as well as three small wounds on big toe, 2nd toe, and 3rd toe. Right foot had a small

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{S5251}	Continued From page 13	{S5251}		

wound on heel, but not as bad as wound on left foot. Sent a picture to medical care provider. Orders given for care and comfort. Provalon boot was bought for left heel and place on heel for protection. Medihoney was placed on coccyx area. Right calcaneus wound was size of quarter; left calcaneus wound was size of fifty-cent piece. All foot wounds are dark brown to blackish in color. Sacrum and coccyx wound are peeling, red, and have raw looking areas on them. Will continue to monitor all wounds."

No further documentation in progress notes. The record lacked documentation of wound assessments and treatment provided.

Interview on 1-21-16 at 1:45 p.m. with Operator/Owner/RN stated and confirmed, "Did not document wound care treatment.

On 1-21-15 at 2:20 p.m., Operator/Owner/RN and surveyor observed resident #3333's wounds on feet. Right foot heel revealed a black closed wound measuring 3.5 Centimeter (CM) by 4.5 CM. Left foot inner heel revealed a black closed wound the size of a nickel.

Progress notes recorded the following: (No date, no time), "Operator/Owner/RN, family members, and certified staff C were present in resident's room while certified staff C was finishing bed bath when resident began what appeared to be a ' classic tonic clonic seizure. ' Family member confirmed that resident had a seizure approximately ten years ago. . . This seizure appeared to last several minutes. Blood began coming out of left side of residents lips and I knew that resident had most likely bitten tongue. Finally, the seizing stopped and resident slept. I spoke with the family and explained that after that

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	B087167	A. BUILDING: _____ B. WING _____	R 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSIONATE CARE WEST	968 N TYLER RD WICHITA, KS 67212

(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
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type of seizure, resident would most likely sleep for a while. Family stayed for approximately thirty more minutes and then left."

There was no further documentation in the progress notes. The record lacked documentation of assessment of mouth and tongue related to bleeding, documentation of vital signs taken following the seizure, and follow up assessment of the resident after the seizure.

The owner/operator/RN failed to ensure resident 3333's record contained 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.

- At 10:15 a.m. on 1-21-16, observed resident #3335 in recliner with family member at side. Resident #3335 skin color pale. Certified staff #A stated resident "is getting ready to pass."

Record review for resident #3335 revealed an admission date of 7-1-11 and diagnoses of Parkinson's disease and Alzheimer's dementia.

The functional capacity screen dated 8-16-15 indicated the resident was unable to perform bathing, dressing, toileting, transferring, and management of medications and treatments; was unable to feed self; required physical assistance for mobility; was frequently incontinent of urine; experienced impaired cognition; impaired ability to communicate and understand communication; was at risk for falls; required a wheelchair for mobility and a mechanical lift for transfers.

The negotiated service agreement and health care service plan dated 8-16-15 documented

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facility staff provided physical assistance with bathing, dressing, toileting, mobility per wheelchair, transfer assistance of one person using mechanical lift or two-person transfer assistance, feeding, and administration of medications and treatments.

Review of the medical care provider orders revealed the following:

10-1-15: Wet to dry dressing change to left leg 2 times a day. Clindamycin (antibiotic) 2 tablets (no dosage written) by mouth 2 times a day for 10 days. Culture wound.

10-5-15: Cipro (antibiotic) 250 milligrams 2 times a day for 10 days for leg infection (based on wound culture results).

11-2-15: Augmentin (antibiotic) 875 milligrams 2 times a day with meals for 10 days for urinary tract infection.

1-8-16 Transport resident to emergency room per emergency medical services due to hemoptysis (the coughing up of blood), diaphoresis, and decreased level of consciousness.

Review of documentation by the owner/operator/RN revealed the following entries:

10-1-15 Blood blister on lower left leg open. Received order from medical care provider for wound culture and wet to dry dressings.

1-8-16 Received call from staff person that resident was not responding, blood pressure 96/38, pulse 76, oxygen saturation 96%. Medical care provider ordered transport to emergency room per emergency medical services due to

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hemoptysis.

The resident record lacked documentation of the resident's response to antibiotic therapy administered for treatment of the wound infection and response to wound care. The record lacked documentation of resident's response to antibiotic therapy for a urinary tract infection. The record lacked documentation that resident returned from the emergency room on 1-8-16.

At 11:10 a.m. on 1-21-16, owner/operator/RN stated the resident's wound on the left lower leg healed and confirmed he/she did not document this in the resident record. Owner/operator/RN stated resident returned to the facility on 1-8-16 and after medical care provider reviewed laboratory results, and the medical care provider instructed the resident to be admitted to the hospital for gastrointestinal bleed. Owner/operator/RN stated resident returned to the facility after spending one night in the hospital and staff began providing comfort care measures to the resident.

The owner/operator/RN failed to ensure resident #3335's record contained 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.

- Record review for resident #3337 revealed an admission date of 2/13/15 and diagnoses of hypertension and stroke.

The functional capacity screen dated 2-13-15 indicated resident required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating; was unable to perform

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management of medications and treatments; was occasionally incontinent of urine; experienced impaired short-term memory, long-term memory, decision-making, and memory recall; impaired ability to communicate and understand communication; and was at risk for falls.

The negotiated service agreement dated 2-13-15 documented services of physical assistance with bathing, dressing, toileting, transferring, walking, and eating; medication and treatment management by facility; and monitor fall risk.

On 1-25-16 at 10:25 a.m., owner/operator/RN stated resident #3337 complained of right shoulder pain on 1-22-16 and an X-ray showed a rib fracture. Owner/operator/RN stated he/she did not know the cause of the rib fracture.

Interview with resident #3337 at 10:40 a.m. on 1-25-16. Resident stated his/her right arm hurt and had to use left arm to raise right arm. Resident could not remember falling or experiencing an injury.

The resident's record lacked documentation of the resident's complaint of right shoulder pain, contact with the resident's medical care provider, and X-ray that determined fracture of right sixth rib.

The owner/operator/RN failed to ensure resident #3337's record contained documentation of all incidents, symptoms, and other indications of injury including the date, time of occurrence, action taken, and results of the action.