STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087125	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE HOMES INC #641	641 N BROADMOOR AVE WICHITA, KS 67206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaints #88016 and #87325 of the above home plus facility on 10/27/15, 10/28/15, and 10/29/15.	S 000		
S5028 SS=E	26-42-101 (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 home 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. This REQUIREMENT is not met as evidenced by:	S5028		

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

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S5028	Continued From page 1 KAR 26-42-101(f)(3) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for 3 (#102, #100, and #101) of 3 residents sampled, the operator failed to report to the department within 24 hours when staff found each cognitively impaired resident on the floor and when staff discovered resident #102 with bruises to hands with cause of injury unknown in order to rule out abuse and/or neglect. Findings included: - Record review for resident #102 revealed an admission date of 2/12/15 and a diagnosis of Alzheimer's dementia. The functional capacity screen dated 2/13/15 indicated the resident required supervision with eating; physical assistance with dressing, toileting, transferring, and mobility; was unable to perform bathing and management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term and long-term memory, decision making, and memory recall; was at risk for falls; and used a wheelchair for mobility. The significant change functional capacity screen dated 10/21/15 indicated the resident was unable to perform bathing, dressing, toileting, transferring, mobility, and management of medications and treatments; required physical assistance with eating; was incontinent of urine; experienced impaired short-term and long-term memory, decision making, and memory recall; was at risk for falls; exhibited socially inappropriate disruptive behaviors; exhibited wandering behaviors; and used a wheelchair for mobility.	S5028		

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S5028	Continued From page 2 The negotiated service agreement and health care service plan dated 2/10/15 documented staff to assist with all activities of daily living, administer medications, resident required two-person assistance to transfer and bed in lowest position due to resident's risk for falls. The negotiated service agreement/health care service plan dated 10/21/15 did not address the resident's risk for falls. Review of the nurse's notes revealed the following times (not reported to the department) staff found resident #102 on the floor: 4/1/15 at 5:25 p.m. licensed nurse #B documented caregiver reported at 11:48 a.m. that resident's alarm sounded and found resident on floor beside bed. Licensed nurse #B documented the resident's bed frame would be removed to make bed closer to floor. 5/25/15 at 4:50 p.m. licensed nurse #B documented caregiver called at 2:52 a.m. to report finding resident on the floor and at 4:17 p.m. resident slid out of wheelchair. 6/28/15 at 6:43 p.m. licensed nurse #D documented staff called at 6:30 a.m. to report resident fell from wheelchair. Resident received a skin tear to back of left hand. 7/23/15 at 7:59 p.m. licensed nurse #B documented resident fell out of bed at 12:00 a.m. Staff found resident on floor after alarm sounded. Mattress and box springs were on floor and will remove box springs. Foam noodle placed on mattress. Resident received a cut to left cheek and at 5:45 a.m. had developed bruising to left eye and nose.	S5028		

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S5028	Continued From page 3 The nurse's notes contained an entry by licensed nurse #A at 12:27 p.m. on 9/28/15 that resident had bruises on the back of both hands. Licensed nurse #A documented "Possible cause of bruising is likely due to resident's habit of rubbing hands vigorously, continuously. Some bruising may also be attributed with resident hitting floor staff members often with the back of (his/her) hands." - Record review for resident #100 revealed an admission date of 1/5/15 and a diagnosis of dementia. The functional capacity screens dated 1/5/15 and 10/5/15 each indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; was occasionally incontinent of urine; experienced impaired short-term and long-term memory, decision making, and memory recall; was at risk for falls; exhibited socially inappropriate disruptive behaviors; and used a wheelchair for mobility. The negotiated service agreement and health care service plan dated 1/5/15 and 10/5/15 documented staff to assist with all activities of daily living, administer medications, and resident required two-person assistance to transfer. The negotiated service agreement/health care service plan dated 1/5/15 documented interventions to address the resident's risk for falls as bed alarm, foam noodle between mattress and box springs, and padded mat on floor beside bed. The negotiated service agreement/ health care service plan dated 10/5/15 listed bed alarm and padded mat on floor beside bed as interventions.	S5028		

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S5028	Continued From page 4 Review of the nurse's notes revealed the following times (not reported to the department) staff found resident #100 on the floor: 2/1/15 at 9:58 p.m. licensed nurse #B documented received call at 11:45 a.m. to report resident on floor in bedroom. Caregiver reported bed alarm did not sound since the alarm had been turned off. Resident had been asleep 30 minutes prior to finding resident on floor. Caregiver reported bruising on right side (area not specified). Resident refused to allow licensed nurse to perform an assessment. 2/28/15 at 11:19 p.m. by licensed nurse #C that caregiver reported resident was found on floor at 1:30 p.m. Resident assessed by this nurse at 4:00 p.m. Resident told nurse that he/she was trying to "pick up the piece of sheet metal." 5/19/15 at 1:59 p.m. by licensed nurse #A as a late entry for 5/17/15 received call from caregiver at 5:20 a.m. on 5/17/15 that caregivers found resident on floor and did not complain of pain until moved from floor to recliner. Emergency medical services called but they determined no need to transport. Hip and pelvis X-ray ordered. (X-ray on 5/18/15 negative for fracture.) 5/19/15 at 2:02 p.m. by licensed nurse #A staff reported at 6:00 p.m. resident slid out of wheelchair. (No documentation of witnessed or unwitnessed incident.) Resident stated "I was trying to get in the car." 6/28/15 at 6:47 p.m. by licensed nurse #D received notice from staff at 1:30 p.m. that resident slid out of wheelchair. (No documentation of witnessed or unwitnessed incident.)	S5028		

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S5028	Continued From page 5 8/30/15 at 11:50 a.m. by licensed nurse #D received call last night from caregiver stating that resident had rolled out of bed. Resident stated he/she rolled out of bed. - Record review for resident #101 revealed an admission date of 8/4/14 and a diagnosis of Alzheimer's dementia. The functional capacity screens dated 8/4/14 and 8/4/15 each indicated the resident required physical assistance with eating, bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; was incontinent of urine; experienced impaired short-term and long-term memory, decision making, and memory recall; was at risk for falls; and used a wheelchair for mobility. The negotiated service agreement and health care service plan dated 8/4/14 and 8/4/15 documented staff to assist with all activities of daily living, administer medications, and resident required two-person assistance to transfer. The negotiated service agreement/health care service plans documented interventions to address the resident's risk for falls as bed alarm, body pillow, padded mat on floor beside bed, and hospital bed in lowest position. Review of the nurse's notes revealed the following times (not reported to the department) staff found resident #101 on the floor: 9/10/14 at 4:21 p.m. licensed nurse #D documented staff found resident sitting on floor mat beside bed. Resident stated was trying to get up.	S5028		

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S5028	Continued From page 6 7/8/15 at 8:43 a.m. licensed nurse #D documented he/she received a call last night that staff heard resident's alarm sound and found resident sitting on floor beside bed. Resident stated he/she needed to go to bathroom. At 12:00 p.m. on 10/28/15 licensed nurse #A stated incidents were only reported to the department if the resident experienced an injury. Licensed nurse #B stated he/she reported incidents to the department if the resident could not explain how the incident occurred. For residents #102, #100, and #101, the operator failed to report to the department within 24 hours when staff found each cognitively impaired resident on the floor and when staff discovered resident #102 with bruises to hands with cause of injury unknown in order to rule out abuse and/or neglect.	S5028		
S5215 SS=E	26-42-104 (d) Disaster and Emergency Preparedness Education (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the home ' s emergency management plan; (2) education of each resident upon admission to the home regarding emergency procedures; (3) quarterly review of the home ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a	S5215		

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S5215	Continued From page 7 secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(d)(3) The facility reported a census of 8 residents. The sample included 3 residents. Based on record review and interview for all residents and employees, the operator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan with employees and residents. Findings included: - At 3:00 p.m. on 10/27/15, licensed nurse #A provided documentation of reviews of the emergency management plan with residents and employees since the last resurvey on 8/21/14. Documentation revealed a review on 9/26/14, 4/7/15, and 7/8/15. At 3:32 p.m. on 10/27/15, when asked for documentation of a review of the emergency management plan with residents and employees for the last quarter of 2014 and the first quarter of 2015, licensed nurse #A stated this was the only documentation of reviews. The operator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan with employees and residents.	S5215		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication	S5315		

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S5315	Continued From page 8 aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(1) The facility reported a census of 8 residents. The sample included 3 residents. Based on	S5315		

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S5315	Continued From page 9	S5315		

observation, interview, and record review for 1 (#100) of 3 sampled residents and 1 (#104) non-sampled resident, licensed nurses and certified medication aides failed to store medications securely and properly in accordance with federal and state laws and regulations.

Findings included:

- At 3:40 p.m. on 10/27/15, observed a locked metal box in the food refrigerator in the facility kitchen. Certified medication aide #B removed and unlocked the box that held 17 syringes each containing 2 milligrams of topical Ativan (anti-anxiety medication).

Note: Ativan is a controlled medication that is to be stored in a separately locked compartment within another locked compartment.

At 3:45 p.m. on 10/27/15, licensed nurse #A confirmed the controlled medication was not stored as required.

Record review for resident #100 revealed an admission date of 1/5/15 and diagnosis of dementia. The functional capacity screen dated 10/5/15 indicated the resident was unable to perform management of medications. The negotiated service agreement and health care service plan dated 10/5/15 documented the service of medication administration by staff in accordance with a medical care provider's order. The resident's record contained a medical care provider's written order for Ativan 1 milligram (mg) per milliliter (ml) topical, apply 2 ml (2 mg) topically 30 minutes prior to shower and 1/2 ml (0.5 mg) topically every 4 hours as needed for agitation.

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S5315	Continued From page 10 Licensed nurses and certified medication aides failed to store a controlled medication securely and properly in accordance with federal and state laws and regulations. - At 10:20 a.m. on 10/27/15, observed a desk and work area in the hallway by a shower room and 2 resident rooms Observed a wire basket with a medication package of twenty half tablets of Seroquel (anti-psychotic) 25 milligrams. A pharmacy return form dated 10/8/15 was wrapped around the medication package. The pharmacy label on the medication packaging documented the name of resident #104. At this same time, licensed nurse #A stated the medication should have been kept locked in the medication storage cabinet. Review of the resident roster revealed the facility managed medications for resident #104. Licensed nurses and certified medication aides failed to store a non-controlled medication securely and properly in accordance with federal and state laws and regulations.	S5315		