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-C 08/19/2015

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 revisit for correction order and notice of action 15-67 and ban on admissions 15-10 of the above home plus facility on 8/17/15, 8/18/15, and 8/19/15.	{S 000}		
{S5155} SS=F	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 reported a census of 7 residents. The sample included 3 residents and 1 resident focus reviewed. Based on record review, interview, and observation for 3 (#1000, #1002, and #1003) of 3 residents sampled, the owner/operator/registered nurse (RN) failed to provide or coordinate necessary health care services in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #1000 on 8/17/15 revealed an admit date of 1/31/15 with diagnoses	{S5155}		

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

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{S5155}	Continued From page 1 of chronic obstructive pulmonary disease, osteoporosis, hypertension, and cerebral vascular accident. The functional capacity screen dated 1/31/15 recorded resident required physical assistance with transfer, walking/mobility, and experienced impaired decision making. The negotiated service agreement and health care service plan dated 1/31/15 recorded resident required physical assistance of one staff for transfer, walking/mobility (resident unable to ambulate), eating, dressing, and toileting. The resident roster provided by the owner/operator/RN on 8/17/15 at 1:25 p.m. identified resident #1000 as a two person transfer and indicated did not have any skin problems. Interview at 2:30 p.m. on 8/17/15 with family members stated they come to facility every day. During interview, observed a large Band-Aid on resident's left arm below the elbow. Family members stated during a transfer by certified staff from wheelchair resident received a skin tear on left arm on 8/16/15. Interview at 3:30 p.m. with resident #1000 revealed residents was not oriented to time, place, and was confused. Resident unable to state how he/she got skin tear to left arm below elbow. Interview at 3:05 p.m. on 8/17/15 with owner/operator/RN stated got a call from (certified staff #A) who stated he/she cleansed wound and applied Band-Aid to a skin tear on left arm.	{S5155}		

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{S5155}	Continued From page 2 The nurse's notes lacked documentation of a skin tear or assessment of wound to left arm. Interview at approximately 3:07 p.m. on 8/17/15 with certified staff #B stated (resident #1000) was a two person transfer then looked at owner/operator/RN and stated he/she could transfer resident with one person assist. Certified staff #B explained that one person could transfer resident but it was easier when 2 staff members transferred resident. Further review of the negotiated service agreement/health care service plan revealed the lack of a description of services to prevent injury to resident's skin when staff provided physical assistance with activities of daily living. At 3:25 p.m. on 8/17/15 owner/operator/RN stated had not observed skin tear and stated certified staff #A used last Band-Aid on resident. Observation of skin tear revealed approximately one inch bruised area around skin tear. The skin tear is approximately 1/2 inch V shaped with approximated edges. The dressing lacked date or name of who changed the dressing. The operator/owner/RN stated, "did not document anything in the record and did not observe skin tear until now. " The owner/operator/RN failed to identify the factors necessary for a safe transfer and develop a care plan and educate staff for safe transfer. - Record review for resident #1002 revealed an admission date of 7/1/15 and diagnoses of Parkinson's disease and hypertension. The functional capacity screen dated 7/1/15 indicated the resident required physical	{S5155}		

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{S5155}	Continued From page 3	{S5155}		

assistance with bathing, dressing, toileting, transferring, mobility, and eating; unable to perform management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, long-term memory, and memory recall; was at risk for falls; required a mechanical lift for transferring, and a wheelchair for mobility.

The negotiated service agreement and health care service plan dated 7/1/15 documented certified staff provided physical assistance with bathing, dressing, toileting, transferring, mobility, eating and administration of medications and treatments. The negotiated service agreement/health care service plan described resident required transfer assistance of 1 person using a mechanical lift or two-person assistance without use of a lift. The amended negotiated service agreement dated 7/22/15 documented "Resident admitted with a calcaneus (heel) pressure wound. Treat per Dr. (doctor) order and facility policy."

At 2:05 p.m. on 8/17/15, asked to observe the resident's pressure ulcer. Observed resident in a recliner in the living room with feet elevated. A pillow was placed under the resident's ankles and a heel protector on each foot. Owner/operator/RN removed the heel protector from the resident's left foot. Observed an area covered with eschar on medial aspect of left heel measuring approximately 2.5 centimeters to 3 centimeters long by 1.5 centimeters wide.

At 2:10 p.m. on 8/17/15, when asked about interventions to promote wound healing and prevent further skin breakdown, the owner/operator/RN stated only the use of a pillow under ankles and heel protectors. When asked

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{S5155}	Continued From page 4	{S5155}		

about "Treat per Dr. (doctor) order and facility policy" listed in the amended negotiated service agreement, owner/operator/RN state he/she did not have a facility policy for treatment and prevention of skin breakdown.
Owner/operator/RN provided a verbal medical care provider's order dated 7/16/15 to keep soft boot on left heel at all times, except for bathing and dressing.

At 2:10 p.m. on 8/17/15, owner/operator/RN also provided documentation he/she sent to resident's medical care provider on 8/10/15 that resident received a cut to skin on elbow when being transferred from wheelchair to shower chair on 8/6/15. Owner/operator/RN documented the cut was 1/2 inch long and Band-Aid applied.

The resident's negotiated service agreement/health care service plan lacked a description of services to prevent injury to resident's skin when staff provided physical assistance with activities of daily living.

For resident #1002, who developed a pressure ulcer and was at risk for impaired skin integrity, the owner/operator/RN failed to provide or coordinate necessary health care services in accordance with the functional capacity screening and the negotiated service agreement.

- Record review for resident #1001 revealed an admission date of 2/13/15 and diagnoses of muscle weakness, difficulty walking, and hypertension.

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

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{S5155}	Continued From page 5	{S5155}		

perform management of medications and treatments; experienced impaired short-term memory, long-term memory, decision making, and memory recall; required a walker and wheelchair for mobility; and was at risk for falls.

The negotiated service agreement and health care service plan dated 2/13/15 documented certified staff provided physical assistance with bathing, dressing, toileting, transferring, mobility, and eating and administered medications and treatments to the resident. The negotiated service agreement and health care service plan documented on 2/23/15 the use of a wedge under mattress and on 2/26/15 the use of a bed alarm as interventions related to the resident's risk for falls.

On 7/26/15 (no time of entry documented), the owner/operator/RN documented in the "Progress Notes" that he/she received a call at 3:18 a.m. from a staff member that he/she heard the resident's bed alarm sound and found resident on the floor of the resident's bedroom. Owner/operator/RN documented that resident complained of groin pain, was sent to the hospital, and found to have a pelvic fracture.

The record contained an amended negotiated service agreement dated 7/30/15 documented the service of physical therapy. The amended negotiated service agreement lacked a description of services related to the resident's risk for falls.

At 2:35 p.m. on 8/17/15, observed resident in bed in his/her bedroom. Resident's full-size bed was positioned with one side against the wall. Observed resident positioned on the outer side of the bed.

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{S5155}	Continued From page 6 At 3:40 p.m. on 8/17/15, owner/operator/RN stated that after resident experienced a pelvic fracture, owner/operator/RN instructed staff members to position resident in middle of full size bed and not close to side of bed. Informed owner/operator/RN of observation of resident positioned on outer side of bed. Owner/operator/RN confirmed staff members did not position resident away from the edge of the bed. Owner/operator/RN stated this was the only new intervention put into place after resident's fall from bed and confirmed the negotiated service agreement lacked interventions related to resident's risk for falls. For resident #1001, who was at risk for falls, the owner/operator/RN failed to provide or coordinate necessary health care services in accordance with the functional capacity screening and the negotiated service agreement.	{S5155}		
{S5185} SS=E	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 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.	{S5185}		

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{S5185}	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-42-206(c) The facility reported a census of 7 residents. The sample included 3 residents and 1 resident focus reviewed. Based on record review, interview, and observation for 1(#1002) of 3 residents sampled and 1 (#1003) of 1 focus review resident, the owner/operator/registered nurse (RN) failed to ensure the provision of a mechanically altered diet and/or thickened liquids prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #1002 revealed an admission date of 7/1/15 and diagnoses of Parkinson's disease and hypertension. The functional capacity screen dated 7/1/15 indicated the resident required physical assistance with eating and experienced impaired short-term memory, long-term memory, and memory recall. The negotiated service agreement dated 7/1/15 documented meal service of three meals a day and snacks when needed of a mechanical soft diet. The record contained a medical care provider's written order dated 7/1/15 for a mechanical soft diet with ground meat. -Record review for resident #1003 revealed an	{S5185}		

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{S5185}	Continued From page 8	{S5185}		

admission date of 3/21/13 with diagnoses of senile dementia, Parkinson's disease, and non-insulin dependent diabetes.

The negotiated service agreement dated 8/16/15 recorded, "Resident unable to feed self, staff will feed resident....Resident is able to feed small food items. Diet low concentrated sugar--advance as tolerated."

The physician order dated 5/7/15 recorded, "Dietary full liquid diet, advance to regular soft as tolerated."

At 2:30 p.m. on 8/17/15, observed certified staff #C administer crushed medication mixed with applesauce to resident #1003. Resident had some of the medication mixture on his/her lips. Asked certified staff #C if resident could have some water to drink to clear medication from mouth. Certified staff #C went to kitchen and placed water in a coffee cup and added thickener to the water. Certified staff #C opened a kitchen cabinet door and pointed to a list of each resident's drink preference with documentation to add 1 1/12 scoops of thickener to resident #1003's liquids in a coffee cup. Certified staff #C stated he/she added 2 scoops of thickener to the water because it depended on the type of fluid for how much thickener was required. Certified staff #C took the thickened liquids to resident and spoon fed to resident.

At 2:35 p.m. on 8/17/15, certified staff #B was preparing the evening meal for residents. Certified staff #B stated certified staff #D wrote the instructions posted on the kitchen cabinet door for thickening resident's fluids. Certified staff #B stated "No" when asked if facility had written instructions from a medical care provider or

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{S5185}	Continued From page 9 licensed dietitian to follow when preparing a therapeutic or mechanically altered diet or thickened liquids. Interview on 8/17/15 at 2:40 p.m. with owner/operator/RN who stated that facility did not have written instructions from a medical care provider or licensed dietitian on how to prepare mechanically altered or therapeutic diets. At 2:50 p.m. on 8/17/15 owner/operator/RN stated used, " Thickened Liquids for Safer Swallowing he/she got off the internet as guide for thickened liquids." The " Thickened Liquids for Safer Swallowing" Instructions lacked the signature of a medical care provider or a licensed dietitian or the date implemented. For residents #1003 and #1002, the owner/operator/RN failed to ensure the provision of a mechanically altered diet and/or thickened liquids prepared according to instructions from a medical care provider or licensed dietitian.	{S5185}		
{S5251} SS=F	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 and 1 resident	{S5251}		

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{S5251}	Continued From page 10	{S5251}		

focus reviewed. Based on record review, observation, and interview for 3 (#1000, #1002, and #1001) 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, action taken, and results of the action.

Findings included:

- Record review for resident #1000 on 8/17/15 revealed an admit date of 1/31/15 with diagnoses of chronic obstructive pulmonary disease, osteoporosis, hypertension, and cerebral vascular accident.

The functional capacity screen dated 1/31/15 recorded resident required physical assistance with transfer, walking/mobility, and experienced impaired decision making.

The negotiated service agreement and health care service plan dated 1/31/15 recorded resident required physical assistance of one staff for transfer, walking/mobility (resident unable to ambulate), eating, dressing, and toileting.

Interview at 2:30 p.m. on 8/17/15 with family members stated they come to facility every day. During interview, observed a large Band-Aid on resident's left arm below the elbow. Family members stated during a transfer by certified staff from wheelchair resident received a skin tear on left arm on 8/16/15.

Interview at 3:05 p.m. on 8/17/15 with owner/operator/RN stated got a call from (certified staff A) who stated he/she cleansed

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{S5251}	Continued From page 11	{S5251}		

wound and applied Band-Aid to a skin tear on left arm.

Interview at 3:30 p.m. with resident #1000 revealed resident was not oriented to time, place, and was confused. Resident unable to state how he/she got skin tears to left arm below elbow.

Further review of the resident record revealed the lack of documentation by the owner/operator/RN of the skin tear, including how the injury occurred and a nursing assessment of the injury.

At 3:25 p.m. on 8/17/15 owner/operator/RN stated had not observed skin tear and stated certified staff #A used last Band-Aid on resident. With owner/operator/RN present, observed a skin tear on left lower arm below elbow approximately one inch bruised area around skin tear. The skin tear is approximately 1/2 inch V shaped with approximated edges. The dressing lacked date or name of who changed the dressing. The operator/owner/RN stated, "did not document anything in the record and did not observe skin tear until now. "

The owner/operator/RN failed to ensure resident #1000's record contained documentation of all incidents and injury including the date, time of occurrence, action taken, and results of the action.

- Record review for resident #1002 revealed an admission date of 7/1/15 and diagnoses of Parkinson's disease and hypertension.

The functional capacity screen dated 7/1/15 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating; unable to

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{S5251}	Continued From page 12	{S5251}		

perform management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, long-term memory, and memory recall; was at risk for falls; required a mechanical lift for transferring, and a wheelchair for mobility.

The negotiated service agreement and health care service plan dated 7/1/15 documented certified staff provided physical assistance with bathing, dressing, toileting, transferring, mobility, eating and administration of medications and treatments. The amended negotiated service agreement dated 7/22/15 documented "Resident admitted with a calcaneus (heel) pressure wound. Treat per Dr. (doctor) order and facility policy."

Review of documentation by the owner/operator/RN in the "Progress Notes" revealed the lack of any documentation of a nursing assessment of the resident's pressure ulcer including the size of the wound, a description of the wound and surrounding skin, and the presence or absence of wound drainage.

At 2:05 p.m. on 8/17/15, asked to observe the resident's pressure ulcer. Observed resident in a recliner in the living room with feet elevated. A pillow was placed under the resident's ankles and a heel protector on each foot.
Owner/operator/RN removed the heel protector from the resident's left foot. Observed an area covered with eschar on medial aspect of left heel measuring approximately 2.5 centimeters to 3 centimeters long by 1.5 centimeters wide. The owner/operator/RN stated he/she had been looking at the wound but had not documented wound assessments in the resident's record and did not have a way to measure the wound.

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{S5251}	Continued From page 13 At 2:10 p.m. on 8/17/15, owner/operator/RN also provided documentation he/she sent to resident's medical care provider on 8/10/15 that resident received a cut to skin on elbow when being transferred from wheelchair to shower chair on 8/6/15. Owner/operator/RN documented the cut was 1/2 inch long and Band-Aid applied. Review of the documentation by the owner/operator/RN in the progress notes revealed the lack of documentation of the incident, action taken, and results of the action with no follow-up assessment. During an interview at 3:50 p.m. on 8/17/15, the owner/operator/RN stated that at approximately 11:30 a.m. on 8/2/15, resident's family members elevated resident's feet with resident sitting in wheelchair. Owner/operator/RN stated the wheelchair tipped over backward with resident hitting head on floor. Owner/operator/RN stated he she performed a neurological assessment of the resident after the fall and again 6 hours later. The owner/operator/RN confirmed he/she did not document the resident's fall, the findings of the neurological assessments, and resident's condition after the incident. The owner/operator/RN failed to ensure resident #1002'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 #1001 revealed an admission date of 2/13/15 and diagnoses of muscle weakness, difficulty walking, and hypertension. The functional capacity screen dated 2/13/15	{S5251}		

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-C 08/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S5251}	Continued From page 14	{S5251}		

indicated the resident required physical assistance with bathing, dressing, toileting, transferring, mobility, and eating; was unable to perform management of medications and treatments; experienced impaired short-term memory, long-term memory, decision making, and memory recall; required a walker and wheelchair for mobility; and was at risk for falls.

The negotiated service agreement and health care service plan dated 2/13/15 documented certified staff provided physical assistance with bathing, dressing, toileting, transferring, mobility, and eating and administered medications and treatments to the resident. The negotiated service agreement and health care service plan documented on 2/23/15 the use of a wedge under mattress and on 2/26/15 the use of a bed alarm as interventions related to the resident's risk for falls.

Review of the "Progress notes" revealed documentation by the owner/operator/RN as follows:

7/26/15 (no entry time documented), the owner/operator/RN documented that he/she received a call from certified staff at 3:18 a.m. that resident fell out of bed and complained of groin pain. Resident was sent to the hospital. The entry lacked an assessment of the resident by the licensed nurse including the resident's vital signs and the time the resident left the facility.

7/26/15 (no entry time documented), Notified resident's medical care provider at 9:57 a.m. Order for transport given.

7/26/15 (no entry time documented), owner/operator/RN documented "Spoke with

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{S5251}	Continued From page 15 (family member) regarding resident's medical condition. (Family member) stated that physician had informed that the CT (computerized tomography) scan revealed a stable fracture in the pelvic ring. (Family member) stated resident would be able" The owner/operator/RN did not complete the entry. 7/28/15 (no entry time documented), resident returned to the facility at approximately 4:40 p.m. The entry lacked a nursing assessment by the owner/operator/RN. At 3:20 p.m. on 8/17/15, owner/operator/RN confirmed he/she did not complete the 7/26/15 entry. Owner/operator/RN stated he/she thought the rest of the entry would have been that resident would be able to return to the facility after hospitalization. The owner/operator/RN failed to ensure resident #1001's record contained documentation of all incidents which included the date, time of occurrence, action taken, and results of the action.	{S5251}		