STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B089082	A. BUILDING: _____ B. WING _____	01/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLEY PLACE #2	618 SW OAKLEY AVE STE B TOPEKA, KS 66606

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S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Home Plus Facility in Topeka, Kansas on 01/05/15, 01/06/15, and 01/07/15. Complaint #77418 also investigated.	S 000		
S5028 SS=D	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	S5028		

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

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S5028	Continued From page 1 by: KAR 26-42-101(f)(3)(C) The census equalled 11 the sample included three Residents with one focus review completed. Based on interviews, and reviews of record, for one of two sampled dementia Residents who left the facility unattended by and unknown to staff, was absent for an undetermined amount of time, and walked through a busy intersection (#189), the Operator failed to ensure the incident thoroughly investigated to rule out potential neglect. Findings included: - Review of record revealed #189 admitted to facility 11/09/14 with diagnoses of Dementia and Hypothyroidism. The current 11/09/14 FCS (functional capacity screen) assessed #189 independent (0) with bathing, mobility, and eating; in need of supervision (1) with toileting and transfers; in need of physical assistance (2) with bathing; unable to perform (3) medication and treatment management; with bladder incontinence; with short and long term memory impairment, decision making and memory recall impairment; with communication impairment; and with falls/unsteadiness. The current 11/09/14 NSA (negotiated service agreement) documented facility staff to wash and dry back in shower... manage medications... walk with and supervise transfers if necessary... will lay out clothes and button or zip if necessary... assist in changing brief as needed... monitor to prevent #189 leaving... and use personal body alarm at night for sleep. Nurse's Notes (NN) of record documented:	S5028		

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S5028	Continued From page 2 11/27/14 - 0905 - received phone call from staff... reported Resident had eloped from building around approximately 9am... front door to building was open... at approximately 0907 staff called to report Resident found across the street in a sports park driveway... instructed staff to initiate 5 minute checks... By review, documented investigation notes failed to specify details such as the time #189 last observed in the facility, the time discovered missing, and the exact length of time Resident missing. The investigation documented "found outside the facility down the street"... but failed to document specifically where #189 discovered. By interview on 01/17/15 at 9:39am, Facility Nurse #D stated it's probably not documented, but we determined by talking to staff at the other house that a staff member came into this house from the other one and noticed the door open... did not get a statement from that staff... determined by talking to both houses that #189 was gone between five and seven minutes... he/she was seen in the living room right after breakfast... not documented but right about 9:00am... The Operator failed to ensure the incident of #189 leaving the facility unattended and unknown by staff thoroughly investigated to rule out neglect.	S5028		
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:	S5085		

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S5085	Continued From page 3 (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. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c) The census equalled 11 the sample included three Residents with one focus review completed. Based on observations, interviews, and reviews of records, for one of three sampled (#189), the Operator failed to ensure designated staff conducted a screening to determine Resident's functional capacity following any significant change in condition. Findings included: - Review of record revealed #189 admitted to facility 11/09/14 with diagnoses of Dementia and Hypothyroidism. The current 11/09/14 FCS (functional capacity screen) assessed #189 independent (0) with bathing, mobility, and eating; in need of supervision (1) with toileting and transfers; in need of physical assistance (2) with bathing; unable to perform (3) medication and treatment management; with bladder incontinence; with short and long term memory impairment, decision making and memory recall impairment; with communication impairment; and with falls/unsteadiness. The FCS failed to identify wandering, impaired decision making, and inappropriate behaviors.	S5085		

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S5085	Continued From page 4 By observations on 01/05/15 at 3:30pm and 5:15pm, #189 in a wheelchair, personal alarm attached to back of sweater, receiving assistance with eating evening meal from visitor sitting next to him/her. By observations on 01/06/15 from 8:45am to 12:12pm, #189 in recliner in living room with personal alarm attached to back of sweater. At 12:12pm Certified Medication Aides #G and #K physically transported #189 to the bathroom in a wheelchair. The wheelchair lacked foot rests and staff verbally prompted #189 repeatedly to lift and/or "step" with feet. Staff continued to repeatedly prompt #189 while lifting/assisting to stand, lowering pants and brief, transferring onto toilet, cleaning perineal area, and transferring back into wheelchair... transported #189 to dining room table and assisted with meal at intervals... #189 extremely dependent on staff for all care needs. By observations on 01/06/15 at 1:58pm #189 transferred from wheelchair at dining room table to recliner in living room area. At 3:59pm Certified Medication Aides #J and #L transported #189 to the bathroom, again with multiple prompts due to no wheelchair foot rests... staff physically lifted, removed brief, and repeatedly prompted #189 to sit on toilet... staff then lifted, cleaned bottom, replaced brief, repositioned clothing, and transferred #189 back into wheelchair... staff then transported #189 to the dining room table. By interview on 01/06/15 at 11:14am Certified Nurse Aide #T stated we do all personal care for #189... push wheelchair, help in and out of wheelchair, wipe and change brief and clothes... cue for meals... no longer into others' rooms... no longer combative... no longer walks by self...	S5085		

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S5085	Continued From page 5 By interview on 01/06/15 at 2:44pm Certified Medication Aide #L stated #189 is different than when he/she got here... was walking around and got unsteady... not sure why... basically do everything for #189 now... started medications... got this way before Christmas... By interview on 01/06/15 at 3:59pm Certified Medication Aides #J and #L stated #189 didn't used to be like this (need total assistance)... less than a month ago... few weeks... used to come in here and toilet self and walk around and everything... By review of record, Nurse's Notes documented multiple instances of inappropriate behaviors and wandering: 11/09/14, 11/10/14, 11/13/14, 12/07/14, 12/20/14, 12/21/14, and 12/23/14. By interview on 01/06/15 at 8:45am Facility Nurse #D stated #189 has changed a lot... ambulatory at admission... lots of behaviors and eloped on Thanksgiving... medications were titrated up, he/she got almost too sedated... have made no change to FCS or NSA yet because... every day he/she's gotten a little more... like medications are wearing off... haven't done an FCS because #189 in a transition stage The Operator failed to ensure designated staff conducted a screening to determine #189's functional capacity following any significant change in condition.	S5085		
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	S5155		

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S5155	Continued From page 6 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 census equalled 11 the sample included three Residents with one focus review completed. Based on observations, interviews, and reviews of record, for one of one sampled with rapid mental and physical decline (#189), and for one non-sampled with documented weight loss and diet order changes (#182), the Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident. Findings included: - Review of record revealed #189 admitted to facility 11/09/14 with diagnoses of Dementia and Hypothyroidism. The record documented #189 admitted with two medication orders: Aspirin and Synthroid. The current 11/09/14 FCS (functional capacity screen) assessed #189 independent (0) with bathing, mobility, and eating; in need of supervision (1) with toileting and transfers; in need of physical assistance (2) with bathing; unable to perform (3) medication and treatment management; with bladder incontinence; with short and long term memory impairment, decision	S5155		

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making and memory recall impairment; with communication impairment; and with falls/unsteadiness.
The current 11/09/14 NSA (negotiated service agreement) documented facility staff to wash and dry back in shower... manage medications... walk with and supervise transfers if necessary... will lay out clothes and button or zip if necessary... assist in changing brief as needed... monitor to prevent #189 leaving... and use personal body alarm at night for sleep.

Nurse's Notes (NN) and Physician's orders (PO) of record documented:
11/09/14 - NN - will have bed alarm due to wandering over night... Resident in great physical condition...
11/10/14 - NN - stumbled near front door... agitated about leaving...
11/13/14 - NN - Resident wandering around two other Residents... agitating others... walked into staff... became combative and swinging at staff... asked family to consider a "mild PRN (as needed medication) to aid with this behavior... will educate staff on redirection of behaviors and institute toileting schedule...
11/22/14 - PO - Vitamin D (supplement) and Bactrim DS (antibiotic for bladder) ordered as result of lab tests (no documented monitoring of Resident's response to new medications)
12/04/14 - PO - ordered increase in Thyroxin (thyroid medication) and addition of Depakote 125mg (milligrams) TID (three times daily) for "mood disorder"... (no documented monitoring of Resident's response to new medication)
12/07/14 - NN - combative behaviors with staff and other Residents... wanders in and out of others rooms... phone call to APRN (advanced practice registered nurse) orders received... family notified... "will monitor"...

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S5155	Continued From page 8 12/07/14 - PO - Clonazepam 0.5mg BID (twice daily) PRN (as needed) for agitation... (no documented monitoring of Resident's response to new medication) 12/11/14 - PO - Depakote increase to 250mg TID, added Melatonin (sleep hormone) 3mg at bedtime daily... (no documented monitoring of Resident's response to new medication) 12/18/14 - PO - Citalopram 10mg every day for 2 weeks, then 20mg every day... (no documented monitoring of Resident's response to new medication) 12/20/14 - NN - slipped and fell in bathroom in water he/she had dipped from toilet with a cup... sent to emergency room for evaluation... (no documented monitoring of Resident's response to injury and emergency room treatment) 12/21/14 - NN - hitting staff and arguing with others... refuses to leave other's room... 12/23/14 - NN - in and out of other's rooms... swinging fists at staff... physician and family notified... continue to monitor... received orders from physician... 12/23/14 - PO - Depakote increased to 375mg TID; added Buspar (psychotropic) 5mg TID; added Lorazepam 0.5mg every four hours PRN anxiety/agitation; changed Clonazepam from PRN to BID (twice daily)... (no documented monitoring of Resident's response to new medication) 12/26/14 - NN - family feels Resident is too sleepy... direct care staff report Resident able to eat and drink, less alert... 12/29/14 - NN - assessed Resident... in bed with eyes closed, answers questions appropriately... doesn't open eyes... update called to physician and to family... 12/29/14 - PO - order to discontinue Clonazepam, Encourage fluids... (no documented monitoring of Resident's response to new medication, no	S5155		

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evidence fluids encouraged or offered, or Resident's response)
01/02/15 - NN - Resident in wheelchair wearing personal alarm for safety... will monitor and update FCS/NSA if Resident continues with this status
01/05/15 - NN - Resident continues to be somewhat sedated... speech is groggy... up in wheelchair... feeding self... impulsive behaviors... attempts to stand without help, is unsteady... encourage fluids... orders received to decrease Depakote...
01/05/15 - PO - order to decrease Depakote to 250mg TID...

By observations on 01/05/15 at 3:30pm and 5:15pm, #189 in a wheelchair, personal alarm attached to back of sweater, receiving assistance with eating evening meal from visitor sitting next to him/her.

By observations on 01/06/15 from 8:45am to 12:12pm, #189 in recliner in living room with personal alarm attached... no observed fluids offered... at 12:12pm Certified Medication Aides #G and #K physically transported #189 to the bathroom in a wheelchair and completed all toileting tasks for Resident... transported #189 to dining room table and assisted with meal at intervals... #189 extremely dependent on staff for all care needs.

By observations on 01/06/15 at 1:58pm #189 transferred from wheelchair at dining room table to recliner in living room area. At 3:59pm Certified Medication Aides #J and #L transported #189 to the bathroom, again completed all toileting tasks for Resident and then transferred #189 back into wheelchair and transported #189 to the dining room table.

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S5155	Continued From page 10 By interview on 01/06/15 at 11:14am Certified Nurse Aide #T stated we do all personal care for #189... no longer into others' rooms... no longer combative... no longer walks by self... By interview on 01/06/15 at 2:44pm Certified Medication Aide #L stated #189 is different than when he/she got here... was walking around and got unsteady... not sure why... basically do everything for #189 now... started medications... got this way before Christmas... By interview on 01/06/15 at 3:59pm Certified Medication Aides #J and #L stated #189 didn't used to be like this (need total assistance)... less than a month ago... few weeks... used to come in here and toilet self and walk around and everything... By interview on 01/06/15 at 6:03pm Facility Nurse #D stated #189 combativeness with staff only... did go into other Resident's room... confirmed no documentation of other interventions attempted... confirmed no documentation of monitoring Resident's response to medication changes... was not aware of an implemented toileting plan, must have been documented by nurse no longer here... stated #189 was still up and going until medication orders of 12/23/14... no documented monitoring of effects of medications on Resident and his/her response to medications... no documentation fluids encouraged or Resident's response to that intervention... #D confirmed these changes and directions to monitor not implemented into the NSA or the Health Service Plan. The Operator failed to ensure a licensed nurse provided or coordinated the provision of	S5155		

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necessary health care services that met the needs of #189 in regard to behaviors, medication changes, physical and mental decline of Resident, and follow up monitoring of these changes.

- Review of record revealed #182 admitted to facility 5/17/13 with diagnoses of Left hip fracture, Atrial fibrillation, Dementia, Osteoarthritis, Anemia, Edema, and Depression.

Functional capacity screen (FCS) dated 11/17/14 assessed #182 in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility; in need of supervision (1) with eating; unable to perform (3) medication and treatment management; with bladder incontinence, with short and long term memory impairment, memory recall impairment, and decision making impairment.
NSA of 11/17/14 documented "Mechanical Soft diet changed to Pureed diet on 12/11/14.

By observations on 01/06/15 at 12:38pm in the kitchen/dining area of facility Certified Medication Aides #G and #K prepared and served a mechanically altered diet to #182. Staff stated Resident had a tendency to "pocket" food in mouth which prompted the order change. Comparison of the served food items with the posted menu and with the Dietician signed preparation directions demonstrated the failure to provide the Dietary services of the NSA.

By observations on 01/06/15 at 5:15pm in the kitchen/dining area of facility, Certified staff prepared and served a mechanically altered diet to #182. Comparison of the served food items with the posted menu and with the Dietician

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signed preparation directions demonstrated the failure to provide the Dietary services of the the NSA.

Review of medical record Vital signs and weight flow sheet documented:
12/10/14 - 135 pounds (12/10/14 aide task sheet documented weight as 129 pounds)
11/19/14 - 130 pounds
9/18/14 - 132 pounds
6/18/14 - 140 pounds
5/22/14 - 146 pounds
4/10/14 - 145 pounds
This flow sheet lacked documentation of consistent monthly weights. This flow sheet documented a 10% weight loss for this Resident in a six month period.

Review of medical care provider orders revealed:
12/11/14 - Pureed Diet. The record lacked documentation of Resident's response to this diet change.
10/23/14 - Mechanical Soft Diet. The record lacked documentation of Resident's response to this diet change.

Review of an Outside Agency Form 12/11/14 - documented "Speech Therapy evaluation - change to pureed diet - Speech Therapy will come 3 - 4 times to provide teaching." The record lacked documentation of these visits, and the Resident's response to these interventions.

By interview on 01/06/15 at 6:48pm, Facility Nurse #D stated #182's diet changed from mechanical soft to pureed on 12/11/14 due to weakness and wasn't eating... and because dentures were not fitting well... no issue with #182 pocketing food. Facility Nurse #D confirmed no follow up monitoring of Resident's response to

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S5155	Continued From page 13 dietary changes as implemented... confirmed weights not obtained consistently on a monthly basis. The Operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of #182 in regard to dietary evaluations, diet order changes, Resident's response to changes, assurance interventions implemented appropriately, and follow up monitoring of these changes.	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. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The census equalled 11 the sample included three Residents with one focus review completed.	S5185		

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All Residents received meal service. Based on observations, interviews, and record reviews, for one of one non sampled with an NSA (negotiated service agreement) specified pureed diet (#182), the Operator failed to ensure the diet prepared according to written instructions from a medical care provider or licensed dietician in accordance with the NSA.

Findings included:

- Review of record revealed #182 admitted to facility 5/17/13 with diagnoses of Left hip fracture, Atrial fibrillation, Dementia, Osteoarthritis, Anemia, Edema, and Depression.

Functional capacity screen (FCS) dated 11/17/14 assessed #182 in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility; in need of supervision (1) with eating; unable to perform (3) medication and treatment management; with bladder incontinence, with short and long term memory impairment, memory recall impairment, and decision making impairment.
NSA of 11/17/14 documented "Mechanical Soft diet changed to Pureed diet on 12/11/14.

By observations on 01/06/15 at 12:38pm in the kitchen/dining area of facility:
1) Certified Medication Aide (CMA) #G using food processor, sauerkraut and very small pieces of summer sausage inside
2) CMA #G and CMA #K state non-sampled #182 is on a mechanical soft diet
3) CMA #K consulted Facility Nurse #D, consulted documentation in medication storage room, and reported back to CMA #G that #182 to receive pureed diet.
4) CMA #K returned the chopped

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sauerkraut/sausage mixture to the food processor and added green beans and peas... processed the mixture... resulted in a mixture of coarsely chopped, fibrous pieces in liquid/runny base... beige/green mix with specks of sausage
5) CMA #K stated this doesn't seem like pureed... I think of pureed as mashed potatoes... I know we had some written directions at one time, I don't know where it is... CMA #K takes bowl of processed mixture to table and feeds #182 a bite... he/she observed to continue to chew and chew for some time
6) Menu posted on kitchen refrigerator documented: Summer Sausage with Sauerkraut, Rolls, Green Beans, Apple Pie and Ice Cream... "for soft and pureed diets remove the skin and do not include sauerkraut"...
7) Confirmed with CMA #G and #K skin not removed from sausage (very small amount) when processed with sauerkraut
8) #182 not served a Roll nor Apple Pie; served peas and white pudding... was later given some ice cream
9) Staff stated #182 recently changed to pureed diet because he/she doesn't like to chew and swallow... liked to "pocket" food...

Review of food preparation notebook provided by Facility Nurse #D revealed:
1) For a Pureed diet the desired texture is smooth like pudding or mashed potatoes without lumps... food to be prepared to consistency of mashed potatoes, squash, and pumpkin pie filling...
2) The ideal pureed food should not require any chewing or added saliva - "ready to swallow"
3) Unless otherwise indicated, only prepare/process one food at a time... several different foods together destroys flavor and color
4) For several foods a "stabilizer" is

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recommended as an ingredient... adds stickiness or cohesiveness like mashed potatoes...
5) Pureed food should be uniform... if you can see chunks or pieces, more processing is needed... should spoon up like yogurt or pudding...
6) "Avoid mixing pureed foods together"
7) Leaf, stem, flower vegetables... add a stabilizer...

By observations on 01/06/15 at 5:15pm in the kitchen/dining area of facility:
1) Menu posted on refrigerator documented: Baked Chicken, Scalloped potato, Corn - for soft or pureed diets substitute peas, Fruit salad
2) Two bowls on table in front of #182, staff feeding #182... staff confirmed one bowl contained pureed tuna/onion, the second bowl contained watery, liquefied fruit cocktail
3) Staff stated did not get chicken because it would be too dry pureed... when asked about added liquids... staff stated we have tried broth... he/she really don't like pureed chicken
4) The served menu lacked scalloped potatoes and corn/peas per posted menu with no substitutes observed

By interview on 01/06/15 at 6:48pm, Facility Nurse #D stated #182's diet changed from mechanical soft to pureed on 12/11/14 due to weakness and wasn't eating... and because dentures were not fitting well... no issue with #182 pocketing food. Facility Nurse #D confirmed the available written preparation directions, signed by the dietician, not followed.

The Operator failed to ensure the provision of a Pureed Diet for #182 in accordance with written directions from a dietician or medical care provider.

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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 census equalled 11 the sample included three Residents with one focus review completed. Based on observations, interviews, and reviews of record, for two of three sampled (#189 and #187) and one non-sampled (#182), the Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury documented in the Resident's record to include the date, time of occurrence, action taken, and the results of the action. Findings included: - Review of record revealed #189 admitted to facility 11/09/14 with diagnoses of Dementia and Hypothyroidism. The record documented #189 admitted with two medication orders: Aspirin and Synthroid. The current 11/09/14 FCS (functional capacity screen) assessed #189 independent (0) with bathing, mobility, and eating; in need of supervision (1) with toileting and transfers; in need of physical assistance (2) with bathing; unable to perform (3) medication and treatment management; with bladder incontinence; with short and long term memory impairment, decision	S5251		

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making and memory recall impairment; with communication impairment; and with falls/unsteadiness.
The current 11/09/14 NSA (negotiated service agreement) documented facility staff to wash and dry back in shower... manage medications... walk with and supervise transfers if necessary... will lay out clothes and button or zip if necessary... assist in changing brief as needed... monitor to prevent #189 leaving... and use personal body alarm at night for sleep.

Nurse's Notes (NN) of #189's medical record documented behaviors of Resident on 11/13/14, 12/07/14, 12/20/14, 12/21/14, and 12/23/14.
The Physician's orders (PO) of the medical record documented dosage adjustments and additional medications ordered 11/22/14, 12/04/14, 12/07/14, 12/11/14, 12/18/14, 12/23/14, and 12/29/14.
The medical record failed to include documentation of alternative interventions attempted to address the behaviors, and failed to include the Resident's response to the medications and to the interventions attempted.

By interview on 01/06/15 at 6:03pm Facility Nurse #D stated #189 combativeness with staff only... confirmed no documentation of other interventions attempted... confirmed no documentation of monitoring Resident's response to medication changes... was not aware of an implemented toileting plan, must have been documented by nurse no longer here... no documented monitoring of effects of medications on Resident and his/her response to medications... no documentation fluids encouraged or Resident's response to that intervention... #D confirmed several interventions attempted and monitoring of Resident took place,

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S5251	Continued From page 19 but these not documented... The Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury documented in #189's record to include the date, time of occurrence, action taken, and the results of the action. - Review of record revealed #182 admitted to facility 5/17/13 with diagnoses of Left hip fracture, Atrial fibrillation, Dementia, Osteoarthritis, Anemia, Edema, and Depression. Functional capacity screen (FCS) dated 11/17/14 assessed #182 in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility; in need of supervision (1) with eating; unable to perform (3) medication and treatment management; with bladder incontinence, with short and long term memory impairment, memory recall impairment, and decision making impairment. NSA of 11/17/14 documented "Mechanical Soft diet changed to Pureed diet on 12/11/14. By observations on 01/06/15 at 12:38pm and at 5:15pm in the kitchen/dining area of facility Certified staff prepared and served a mechanically altered diet to #182. Staff stated Resident had a tendency to "pocket" food in mouth which prompted the order change. Review of medical record Vital signs and weight flow sheet documented: 12/10/14 - 135 pounds (12/10/14 aide task sheet documented weight as 129 pounds) 11/19/14 - 130 pounds 9/18/14 - 132 pounds 6/18/14 - 140 pounds	S5251		

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5/22/14 - 146 pounds
4/10/14 - 145 pounds
This flow sheet lacked documentation of consistent monthly weights. This flow sheet documented a 10% weight loss for this Resident in a six month period.

Review of medical care provider orders revealed:
12/11/14 - Pureed Diet. The record lacked documentation of Resident's response to this diet change.
10/23/14 - Mechanical Soft Diet. The record lacked documentation of Resident's response to this diet change.

Review of an Outside Agency Form 12/11/14 - documented "Speech Therapy evaluation - change to pureed diet - Speech Therapy will come 3 - 4 times to provide teaching." The record lacked documentation of these visits, and the Resident's response to these interventions.

The Nurse's Notes of the record lacked documentation of these signs, symptoms, indications of illness, actions taken, and results of the actions.

By interview on 01/06/15 at 6:48pm, Facility Nurse #D stated #182's diet changed from mechanical soft to pureed on 12/11/14 due to weakness and wasn't eating... and because dentures were not fitting well... no issue with #182 pocketing food. Facility Nurse #D confirmed no follow up documentation of interventions or Resident's response to the interventions.

The Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury documented in #182's record to include the date, time of occurrence, action

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S5251	Continued From page 21 taken, and the results of the action. - Review of record revealed #187 admitted to facility 6/28/14 with diagnosis of Dementia. The current functional capacity screen assessed #187 in need of assistance with toileting; in need of supervision with bathing; unable to perform medication management; and independent with dressing, transfers, mobility, and eating. A Nurse's Note of 7/03/14 documented #187 "continues to go to door and attempt to leave but has been re-directed"... A Nurse's Note of 7/11/14 documented #187 eloped facility and was found outside on the back patio. A Nurse's Note of 10/09/14 documented #187 found on floor... with quarter size goose egg in center back of Resident's head... alert and oriented to self... Dr to be notified when he/she comes to visit... The medical record lacked documentation of events between 6/28/14 and 7/03/14... (continues to go to...). The medical record lacked documentation of interventions, actions taken, staff responses to these symptoms, and lacked the Resident's response to the actions taken. The medical record lacked documentation of interventions and Resident response to actions taken after the elopement on 7/11/14. The medical record lacked documentation of interventions, actions taken, staff responses to the incident, and Resident's response to the action taken when striking head with a resulting "goose egg" injury. On 01/06/15 at 5:38pm, Facility Nurse #D	S5251		

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S5251	Continued From page 22 confirmed the above incidents lacked follow up documentation as required to include the date and time of Resident's continued wanderings between 6/28/14 and 7/03/14; the actions taken, and the Resident's response to the actions taken in regard to the Resident's elopement and fall with head injury. The Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury documented in #187's record to include the date, time of occurrence, action taken, and the results of the action.	S5251		
S5315 SS=E	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication 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.	S5315		

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S5315	Continued From page 23 (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)(4) The census equalled 11 the sample included three Residents with one focus review completed. The facility identified all Residents with facility managed medications and treatments. Based on observations, interviews, and reviews of records, for one non sampled Resident who used insulin pens (#180), and for any Resident of facility who utilized insulin pens, the Licensed nurse and certified medication aides (CMA) failed to: Ensure all medications and biologicals stored in accordance with each manufacturer's recommendations, in regard to manufacturer directions to store in use administration pens of Lantus Insulin and Humalog Insulin at room temperature once opened, and to discard insulin pen 28 days after opening. Findings included: - Observations on 01/05/15 at 4:15pm in kitchen refrigerator/freezer area of facility, revealed insulin pens stored in a locked tackle box in the refrigerator. The tackle box included prescription	S5315		

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S5315	Continued From page 24 labeled boxes with unopened Lantus and Humalog insulin pens inside. The tackle box included open and in use Lantus and Humalog insulin pens. These in use pens lacked "date opened" labeling. On 01/05/15 at 4:15pm, Facility Nurse #D and Certified Medication Aide #G stated they were not aware opened and in use insulin pens to be stored at room temperature. Review of the boxes/packages and manufacturer inserts revealed directions to discard 28 days after opening; unopened pens to be refrigerated; open and in use pens to be stored at room temperature and not refrigerated. Facility Nurse #D and CMA #G stated the in use pens were typically labeled with the date open, but suspected the permanent marker residue had been rubbed off. The Licensed nurse and CMA's failed to ensure insulin pens for #180 stored in accordance with manufacturer' recommendations.	S5315		