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	N094001	A. BUILDING: _____ B. WING _____	08/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL LIVING CENTER	102 E LANE DRIVE JOHNSON, KS 67855

(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 resurvey at the above named facility on 7-29-14, 7-30-14, 7-31-14, 8-4-14, 8-5-14, and 8-6-14.	S 000		
S3030 SS=D	26-41-101 (g) Availability of Policies and Procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(g) The facility identified a census of 13 Residents. The sample included 3 Residents. Based on observation and interview for all Residents, the Operator failed to ensure policies and procedures related to Resident services are available to staff, each Resident, legal representatives of Residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to Residents. Findings included: - Tour of facility on 7-29-14 revealed no notice of availability for policy and procedures. Interview on 7-29-14 at 1:45 p.m. with the	S3030		

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

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S3030	Continued From page 1 Operator stated, "Did not have anything posted about policy and procedures." For all Residents, the Operator failed to ensure policies and procedures related to Resident services are available to staff, each Resident, legal representatives of Residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to Residents.	S3030		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (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)(2) The facility identified a census of 13 Residents. The sample included 3 Residents. Based on record review, interview, and observation for 1 (#555) of 3 Residents sampled, the designated staff failed to conduct a Functional Capacity Screen (FCS) following a significant change in condition for fractured humerus and left leg laceration with sutures and infection.	S3081		

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S3081	Continued From page 2 Findings included: - Record review for Resident #555 revealed an admit date of 5-8-14 with diagnoses of Hypertension, Osteopenia, Spinal Stenosis, Adrenal Mass and Chronic Low Back Pain. The Functional Capacity Screen (FCS) dated 4-14-14 recorded Resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, management of medications/treatments, bladder incontinence, no impairment of cognition, and recorded falls/unsteadiness as a current or recent problem. The Negotiated Service Agreement (NSA) dated 5-8-14 recorded Resident independent with all activities of daily living and self-administered medications. The Resident Service Plan (RSP) dated 5-8-14 recorded Resident self-administered own medication, independent with dressing, shower/bathing, toileting, and mobility. The Resident Care Notes recorded the following: 5-26-14 (no time), "Resident (#555) lost balance getting out of bed to go to restroom, fell on left shoulder and side. Spouse yelled for staff who found (Resident) on knees with right arm on night stand beside bed. Blood Pressure (B/P) 101/64, Pulse (P) 93, Respirations (R) 20. Resident complained of left arm pain and shoulder pain on back. (Certified Staff G and Licensed Nurse A) transferred Resident to wheelchair and noted had open wounds to both knees. Licensed Nurse A transferred Resident to the hospital. X-rays showed a break under the left ball of shoulder to the arm. Left arm was put in a sling, knees were	S3081		

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S3081	Continued From page 3	S3081		

cleaned and bandaged. Orders to clean knees every other day apply polypore as needed and apply arm sling to 90 degree angle as comfort allows. Physician stated it may take two to three months to heal. Resident transferred back to facility. " Licensed Nurse A.

The X-Ray report from hospital recorded: Comminuted surgical neck fracture of the humerus with impaction.

A significant change FCS was not conducted.

Amended RSP on 5-26-14 recorded fall with comminuted neck fracture of the left humerus, assist with showers, dressing, and making bed.

7-18-14 at 4:15 a.m., "Resident fell in room returning from the bathroom. Resident did not know what he/she hit leg on but received a laceration. Certified Staff J called the Operator who called Emergency Medical Services (EMS) to transport Resident to the hospital. EMS returned Resident from hospital and had received sutures. Orders how to care for wound will be accompanied Resident." Signed Operator.

7-27-14 (no time) " Changed left leg dressing. Stitches intact, noted redness and bruising with small amount of serous sanguineous drainage less than one half inch, diameter of a dime. . . . . Laceration was cleansed with normal saline patted dry and dry dressing applied." Licensed Nurse C.

A significant change FCS was not conducted following hospitalization indicating resident #555

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S3081	Continued From page 4 no longer independent with treatments. On 7-30-14 at 11:00 a.m., observed left leg wound for Resident #555. The vertical wound was approximately 8 centimeters (CM) long by 1 CM wide on left outer lower leg below the knee. The area has approximately 2 CM reddened area around the wound. The wound had upper and lower sutures removed. Four sutures remain in the middle of the wound. Approximately 4 CM blistered area in middle of wound was peeling away from the laceration and dark in color. Observed Certified Staff F cleanse area with normal saline, pat dry, apply Neosporin, non-adhesive bandage and kling wrap. Interview on 7-30-14 at approximately 11:25 a.m. with Resident stated, "He/She did not know how he/she got the laceration but did fall and blood was everywhere. " The Resident further stated he/she " may have hit leg on edge of bed frame but was not sure." Interview on 7-30-14 at 11:30 a.m. with Operator/Certified Staff confirmed the record lacked a significant change in condition FCS. For Resident #555, the designated staff failed to conduct a FCS following a significant change in condition for fractured humerus and left leg laceration with sutures and infection.	S3081		
S3155 SS=F	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each	S3155		

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S3155	Continued From page 5	S3155		

resident and are in accordance with the functional capacity screening and the negotiated service agreement.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(a)

The facility identified a census of 13 Residents. The sample included 3 Residents. Based on record review, observation, and interviews for 2 (#555 and #444) of 3 Residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services related to risk for falls, care of residents following fractures, and care and ongoing monitoring of a laceration. Resident #555 experienced 3 falls, 2 of which required emergency medical care with diagnoses of fractured left shoulder and leg laceration that required sutures. Resident #444 experienced 5 slips/falls, one of which resulted in fractured ribs.

Findings included:

- Record review for Resident #555 revealed an admit date of 5-8-14 with diagnoses of Hypertension, Osteopenia, Spinal Stenosis, Adrenal Mass and Chronic Low Back Pain.

The Functional Capacity Screen (FCS) dated 4-14-14 recorded Resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, management of medications/treatments, bladder incontinence, no impairment of cognition, and recorded falls/unsteadiness as a current or recent problem.

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S3155	Continued From page 6 The Negotiated Service Agreement (NSA) dated 5-8-14 recorded Resident independent with all activities of daily living and self-administered medications. The Resident Service Plan (RSP) dated 5-8-14 recorded Resident self-administered own medication, independent with dressing, shower/bathing, toileting, and mobility. The RSP lacked interventions to address Resident #555 ' s risk for falls falls/unsteadiness. The Resident Care Notes recorded the following: 5-8-14 (no time) admitted to facility. Licensed Nurse A. 5-26-14 (no time), "Resident (#555) lost balance getting out of bed to go to restroom, fell on left shoulder and side. Spouse yelled for staff who found (Resident) on knees with right arm on night stand beside bed. Blood Pressure (B/P) 101/64, Pulse (P) 93, Respirations (R) 20. Resident complained of left arm pain and shoulder pain on back. (Certified Staff G and Licensed Nurse A) transferred Resident to wheelchair and noted had open wounds to both knees. Licensed Nurse A transferred Resident to the hospital. X-rays showed a break under the left ball of shoulder to the arm. Left arm was put in a sling, knees were cleaned and bandaged. Orders to clean knees every other day apply polysporin as needed and apply arm sling to 90 degree angle as comfort allows. Physician stated it may take two to three months to heal. Resident transferred back to facility. " Licensed Nurse A. The X-Ray report from hospital recorded: Comminuted surgical neck fracture of the	S3155		

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humerus with impaction.

Amended RSP on 5-26-14 recorded fall with comminuted neck fracture of the left humerus, assist with showers, dressing, and making bed. The NSA and RSP lacked interventions to address care of resident following the fracture.

5-27-14 (no time) "(Licensed Nurse A) was called to facility by (Certified Staff H) who asked for assistance in getting Resident off the floor and transfer to wheelchair then toilet. Resident had tried to transfer self from wheelchair to toilet. (Certified Staff H) assisted Resident to the floor in restroom and called (Licensed Nurse A). Resident was not injured and was instructed to call for assistance when needed to move from one place to another. The Resident was again showed how to use phone to call for assistance." Licensed Nurse A.

The record lacked further documentation regarding Resident's fracture or wearing sling from 5-26-14 through 7-2-14.

The NSA and RSP lacked interventions to address the ongoing care of the resident ' s fracture and the continued risk for falls.

7-3-14 (no time) "(Licensed Nurse I) elevated Resident's left arm and informed Resident to wear sling in daytime and off at night. Sling should be at 90 degrees." Licensed Nurse C.

7-6-14 (no time) " Encouraged Resident to wear sling on left arm during daytime and off at night. " Licensed Nurse C.

7-18-14 at 4:15 a.m., "Resident fell in room returning from the bathroom. Resident did not

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know what he/she hit leg on but received a laceration. Certified Staff J called the Operator who called Emergency Medical Services (EMS) to transport Resident to the hospital. EMS returned Resident from hospital and had received sutures. Orders how to care for wound will be accompanied Resident." Signed Operator.

The RSP lacked interventions for the care and services related to the laceration with sutures and to observe for signs and symptoms of infection and continued to lack interventions to address the Resident's risk for falls.

The record lacked further documentation until 7-27-14.

7-27-14 (no time) " Changed left leg dressing. Stitches intact, noted redness and bruising with small amount of serous sanguineous drainage less than one half inch, diameter of a dime. . . . . Laceration was cleansed with normal saline patted dry and dry dressing applied." Licensed Nurse C.

The record lacked further documentation after 7-27-14.

On 7-30-14 at 11:00 a.m., observed left leg wound for Resident #555. The vertical wound was approximately 8 centimeters (CM) long by 1 CM wide on left outer lower leg below the knee. The area has approximately 2 CM reddened area around the wound. The wound had upper and lower sutures removed. Four sutures remain in the middle of the wound. Approximately 4 CM blistered area in middle of wound was peeling away from the laceration and dark in color. Observed Certified Staff F cleanse area with normal saline, pat dry, apply Neosporin,

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non-adhesive bandage and kling wrap.

Interview on 7-30-14 at approximately 11:25 a.m. with Resident stated, "He/She did not know how he/she got the laceration but did fall and blood was everywhere. " The Resident further stated he/she " may have hit leg on edge of bed frame but was not sure."

Interview on 7-30-14 at 11:30 a.m. with Operator/Certified Staff stated on 7-27-14 had a message to call the clinic to make an appointment for Resident and he/she took Resident#555 to the physician appointment on 7-29-14. The physician removed 6 of 10 sutures and left 4 sutures in place. The physician said the leg look angry and wrote a prescription for antibiotics to be started. The Operator/Certified staff did not notify a nurse when returned from the physician appointment.

For Resident #555 who experienced 3 falls, sustained a fractured shoulder and a leg laceration requiring sutures that became infected, the operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services to address this resident ' s ongoing risk for falls, the care of the resident following a shoulder fracture, and care and ongoing monitoring of the wound following the laceration.
- Record review for Resident #444 revealed an admit date of 6-1-11 with diagnoses of Hypertension, Spinal Stenosis, and Hypothyroidism.
The FCS dated 10-28-13 recorded Resident #444 independent with walking/mobility, eating, communication, required supervision with transfer, required physical assistance with bathing, dressing, toileting, management of

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medications, bladder incontinence, experienced short-term memory loss and impaired memory recall, and recorded falls/unsteadiness and impaired vision as current or recent problems.

The Negotiated Service Agreement (NSA) dated 11-1-13 recorded staff to assist with shower, dressing, and toileting. Certified Staff or Licensed Nurse to administer medications.
The Resident Service Plan (RSP) dated 8-19-13 recorded Resident required staff to administer medications, assist with dressing, bathing, and getting ready for bed.
The NSA and RSP lacked a description of services to address fall risk or supervision with transfers.

The Resident Care Notes (RCN) recorded the following:
Documentation of falls on 4-29-13, 6-1-13 and 9-26-13 when resident slid to floor when reaching for something or attempting to transfer to or from his/her wheelchair.

12-7-13 at 6:50 p.m. " Found Resident on floor sitting by bathroom. Resident said slid down and was not hurt. Called (Licensed Nurse B) on call. " Certified Staff G.

12-10-13 1:45 p.m. " Complained of pain in left hip and lower back. Stated he/she slid down to the floor and his/her back and left hip really hurting today. The clinic was telephoned for the physician to call back. " Licensed Nurse C.

12-10-13 4:00 p.m. " Continued with back pain and left side hip pain. Difficult with breathing with complaint of pain. Left hip hurts. B/P 160/84, P 65, R 18, T 98.6. Telephoned the physician and left message. " Licensed Nurse C.

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12-10-13 4:50 p.m. " Received a telephone call from clinic. Described signs and symptoms including left side and hip pain, unable to take a deep breath without encouragement. Tylenol 500 milligrams two tablets administered. An appointment set for 12-11-13 at 2:00 p.m. with physician. Notified Resident. " Licensed Nurse C.

12-10-13 5:05 p.m. " Clinic staff called stating Resident ' s appointment will need to be rescheduled. The physician will return to work on 12-16-13. " Licensed Nurse C.

12-12-13 (no time), " Appointment with Advanced Practice Registered Nurse (APRN) for complaint of pain in left side and back after fall, {slide to floor}. Chest X-Ray completed. Received a call from the APRN stating Resident has hair line fracture of rib. " Licensed Nurse C.

Late entry for 12-12-13 " Resident ' s new diagnoses: Pleural Effusion and Fractured Rib. Encourage deep breathing/cough and encourage fluids. " Licensed Nurse C.

The NSA and RSP lacked interventions to address continued fall risk and care following rib fracture.

Interview on 7-30-14 at 9:10 a.m. with Resident #444 stated if needed help would call for help on the phone. Resident broke ribs when someone tried to pick him/her up off floor but did not recall who or when.

Interview on 7-30-14 at 5:30 p.m. with Licensed Nurse C stated did not fill out an incident report from fall on 12-10-13 or amend the Resident Service Plan. The Licensed Nurse confirmed the

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S3155	Continued From page 12 RSP lacked interventions for falls/unsteadiness. For Resident #444, the operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services for this resident who was identified with falls/unsteadiness and experienced 5 slips/falls, including one that resulted in fractured ribs. For 2 (#555 and #444) of the 3 sampled residents, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services related to risk for falls, care of residents following fractures, and care and ongoing monitoring of a laceration.	S3155		
S3166 SS=F	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility identified a census of 13 Residents. The sample included 3 Residents. Based on record review and interviews for 2 (#555, #777) of 3 Residents sampled, the Licensed Nurse failed to appropriately delegate nursing procedures (as outlined under the Kansas nurse practice act) to	S3166		

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Certified Staff. The certified staff ' s personnel records failed to document education and training and competency assessment for wound care and dressing changes for Resident #555 and Finger Stick Blood Sugar (FSBS) checks for Resident #777. The Licensed Nurse further failed to ensure documentation related to the delegation of FSBS and wound care was included in the Residents plan of care.

Findings included:

- Record review for Resident #555 revealed an admit date of 5-8-14 with diagnoses of Hypertension, Osteopenia, Spinal Stenosis, Adrenal Mass and Chronic Low Back Pain.

The Functional Capacity Screen (FCS) dated 4-14-14 recorded Resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, management of medications/treatments, bladder incontinence, cognition, and falls/unsteadiness.

The Negotiated Service Agreement (NSA) dated 5-8-14 recorded Resident independent with all activities of daily living and self-administered medications.

The Resident Service Plan (RSP) dated 5-8-14 recorded Resident self-administered own medication, independent with dressing, shower/bathing, toileting, and mobility.

Amended RSP on 5-26-14 recorded fall with comminuted neck fracture of the left humerus, assist with showers, dressing, and making bed.

The Resident Care Notes recorded the following:

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5-8-14 (no time) admitted to facility. Licensed Nurse A.

5-26-14 (no time), "Resident (#555) lost balance getting out of bed to go to restroom, fell on left shoulder and side. Spouse yelled for staff who found (Resident) on knees with right arm on night stand beside bed. Blood Pressure (B/P) 101/64, Pulse (P) 93, Respirations (R) 20. Resident complained of left arm pain and shoulder pain on back. (Certified Staff G and Licensed Nurse A) transferred Resident to wheelchair and noted had open wounds to both knees. Licensed Nurse A transferred Resident to the hospital. X-rays showed a break under the left ball of shoulder to the arm. Left arm was put in a sling, knees were cleaned and bandaged. Orders to clean knees every other day apply polysporin as needed and apply arm sling to 90 degree angle as comfort allows. Physician stated it may take two to three months to heal. Resident transferred back to facility. Licensed Nurse A.

The Treatment Records (TR) recorded on 6-1-14 " check and clean wound on left elbow at 8:00 a.m. and 8:00 p.m. "

TR documented certified staff were completing this treatment. Review of personnel records lacked documentation of education and training and competency assessment for wound care and resident ' s NSA and RSP lacked documentation of delegation of this task to certified staff.

Resident Care notes further recorded:
7-18-14 at 4:15 a.m., "Resident fell in room returning from the bathroom. Resident did not know what he/she hit leg on but received a

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laceration. Certified Staff J called the Operator who called Emergency Medical Services (EMS) to transport Resident to the hospital. EMS returned Resident from hospital and had received sutures. Orders how to care for wound will be accompanied by Resident." Signed Operator.

The orders dated 7-18-14 recorded the following:
1.) Keep wound clean and dry.
2.) If you were given a dressing, you should change it at least once a day.
3.) Wash wound with soap and water two times a day. Rinse the wound off with water to remove all soap.
Pat the wound dry with a clean towel.
4.) After cleaning, apply a thin layer of polysporin ointment. This will help keep the dressing from stick
sticking.
5.) You may shower as usual after the first 24 hours. Do not soak the wound in water until sutures are
removed.
6.) Get sutures removed as directed by physician.

The TR recorded on 7-18-14 thru 7-30-14 " change bandage, clean wound, then apply triple antibiotic ointment at 8:00 p.m. every day, " and was initialed by certified staff that performed the treatment. Review of personnel records lacked documentation of education and training and competency assessment for wound care and resident ' s NSA and RSP lacked documentation of delegation of this task to certified staff.

On 7-30-14 at 11:00 a.m., observed left leg

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wound for Resident #555. The wound was approximately 8 centimeters (CM) long by 1 CM wide up and down on left outer lower below knee. The area has approximately 2 CM reddened area around the wound. The wound had upper and lower sutures removed. Four sutures remain in the middle of the wound. Approximately 4 CM blistered area in middle of wound was peeling away from the laceration and dark in color. Observed Certified Staff F cleanse area with normal saline, pat dry, apply Neosporin, non-adhesive bandage and kling wrap.

For Resident #555, the Operator failed to ensure the Licensed Nurse appropriately delegate this nursing procedures to certified staff under the Kansas nurse practice act, K.S.A.65-1124 when the licensed nurse failed to provide education and competency assessment of certified staff who performed dressing changes and wound care and failed to ensure the residents negotiated service agreement provided a description of the delegated tasks.

- Record review for Resident #777 revealed an admit date of 6-14-12 with diagnoses Dementia, Hypertension, Atrial Fibrillation, General Weakness and Urinary Tract Sepsis.

The Functional Capacity Screen (FCS) dated 6-12-13 and 6 -5 14 recorded Resident #777 required physical assistance with management of medications and treatments.

The Negotiated Service Agreement (NSA) dated 6-5-14 recorded resident required assistance with management of medications and treatments.

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S3166	Continued From page 17 Review of physician orders dated 5-23-13 recorded Fingerstick Blood Sugar (FSBS) two hours after meal every day at 9:00 p.m. Review of the Treatment Record (TR) dated 7-1-14 recorded FSBS performed every evening at 9:00 p.m. by Certified Staff. Review of personnel records lacked documentation of education and training and competency assessment for FSBS and resident ' s NSA and RSP lacked documentation of delegation of this task to certified staff. Interview on 7-30-14 at 3:10 p.m. with Operator stated, "(He/She) did not have delegations of duties from nursing staff, anything written in the NSA for delegations of duties, or anything written in personnel records for task delegated." For Resident #777, the Operator failed to ensure Licensed Nurse delegated duties to Certified Staff for FSBS. For Resident s #555 and #777, the Licensed Nurse failed to appropriately delegate nursing procedures (as outlined under the Kansas nurse practice act) to Certified Staff related to Finger Stick Blood Sugar (FSBS) checks and wound care. The Licensed Nurse failed to ensure documentation related to the delegation of FSBS and wound care was included in the Residents plan of care and failed to ensure document education, training and competency assessment for FSBS and wound care in the personnel files of each designated Certified Staff.	S3166		
S3261 SS=F	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

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S3261	Continued From page 18 (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 26-41-105(f)(11) The facility identified a census of 13 Residents. The sample included 3 Residents. Based on record review, observation, and interviews for 2 (#555 and #444) of 3 Residents sampled, the operator failed to ensure documentation of all incidents, signs/symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action taken. Findings included: - Record review for Resident #555 revealed an admit date of 5-8-14 with diagnoses of Hypertension, Osteopenia, Spinal Stenosis, Adrenal Mass and Chronic Low Back Pain. The Functional Capacity Screen (FCS) dated 4-14-14 recorded Resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating m management of medications/treatments, bladder incontinence, cognition, and falls/unsteadiness. The Negotiated Service Agreement (NSA) dated 5-8-14 recorded Resident independent with all activities of daily living and self-administered	S3261		

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medications.

The Resident Service Plan (RSP) dated 5-8-14 recorded Resident self-administered own medication, independent with dressing, shower/bathing, toileting, and mobility.

Amended RSP on 5-26-14 recorded fall with comminuted neck fracture of the left humerus, assist with showers, dressing, and making bed.

The Resident Care Notes recorded the following: 5-8-14 (no time) admitted to facility. Licensed Nurse A.

5-26-14 (no time), "Resident (#555) lost balance getting out of bed to go to restroom, fell on left shoulder and side. Spouse yelled for staff who found (Resident) on knees with right arm on night stand beside bed. Blood Pressure (B/P) 101/64, Pulse (P) 93, Respirations (R) 20. Resident complained of left arm pain and shoulder pain on back. (Certified Staff G and Licensed Nurse A) transferred Resident to wheelchair and noted had open wounds to both knees. Licensed Nurse A transferred Resident to the hospital. X-rays showed a break under the left ball of shoulder to the arm. Left arm was put in a sling, knees were cleaned and bandaged. Orders to clean knees every other day apply polysporin as needed and apply arm sling to 90 degree angle as comfort allows. Physician stated it may take two to three months to heal. Resident transferred back to facility. Licensed Nurse A.

The X-Ray report from hospital recorded: Comminuted surgical neck fracture of the humerus with impaction.

5-27-14 (no time) "(Licensed Nurse A) was called

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to facility by (Certified Staff H) who asked for assistance in getting Resident off the floor and transfer to wheelchair then toilet. Resident had tried to transfer self from wheelchair to toilet. (Certified Staff H) assisted Resident to the floor in restroom and called (Licensed Nurse A). Resident was not injured and was instructed to call for assistance when needed to move from one place to another. The Resident was again showed how to use phone to call for assistance." Licensed Nurse A.

The record lacked documentation about Resident's fracture or wearing sling from 5-26-14 through 7-2-14.

6-6-14 11:00 a.m. Resident complained of not feeling well and having low energy. B/P 140/60, T 99, P 84, R 22. Nurse on call (Licensed Nurse D) notified. Certified Staff F.

Notes lacked documentation of actions taken and results of actions taken.

7-3-14 (no time) "(Licensed Nurse I) elevated Resident's left arm and informed Resident to wear sling in daytime and off at night. Sling should be at 90 degrees." Licensed Nurse C.

7-6-14 (no time) Encouraged Resident to wear sling on left arm during daytime and off at night. Licensed Nurse C.

7-18-14 at 4:15 a.m., "Resident fell in room returning from the bathroom. Resident did not know what he/she hit leg on but received a laceration. Certified Staff J called the Operator who called Emergency Medical Services (EMS) to transport Resident to the hospital. EMS returned Resident from hospital and had received sutures.

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S3261	Continued From page 21 Orders how to care for wound will be accompanied by Resident." Signed Operator. The Resident Notes lacked an assessment with written description of wound/laceration, sign/symptoms, action taken and results of actions taken. The record lacked further documentation until 7-27-14. 7-27-14 (no time) " Changed left leg dressing. Stitches intact, noted redness and bruising with small amount of serous sanguineous drainage less than on half inch diameter of a dime. The injury occurred on 7-17-14 (happened on 7-18-14). Resident needs an appointment with the physician on Monday 7-28-14 to check laceration and possible suture removal. Laceration was cleansed with normal saline patted dry and dry dressing applied." Licensed Nurse C. The record lacked documentation of follow up physician appointment, signs/symptoms of infection, description of wound, sutures removed, and why Resident taking antibiotics. On 7-30-14 at 11:00 a.m., observed left leg wound for Resident #555. The wound was approximately 8 centimeters (CM) long by 1 CM wide up and down on left outer lower below knee. The area has approximately 2 CM reddened area around the wound. The wound had upper and lower sutures removed. Four sutures remain in the middle of the wound. Approximately 4 CM blistered area in middle of wound was peeling away from the laceration and dark in color. Observed Certified Staff F cleanse area with	S3261		

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normal saline, pat dry, apply Neosporin, non-adhesive bandage and kling wrap.

Interview on 7-30-14 at approximately 11:25 a.m. with Resident stated, "He/She did not know how he/she got the laceration but did fall and blood was everywhere. The Resident further stated he/she may have hit leg on edge of bed frame but was not sure."

Interview on 7-30-14 at 11:30 a.m. with Operator/Certified Staff stated on 7-29-14 took Resident to the physician appointment. The physician removed 6 of 10 sutures and left 4 sutures in place. The physician said the leg look angry and wrote a prescription for antibiotics to be started. The Operator/Certified staff did not notify a nurse when returned from the physician appointment.

For Resident #555, the operator failed to ensure 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 #444 revealed an admit date of 6-1-11 with diagnoses of Hypertension, Spinal Stenosis, and Hypothyroidism.

The annual Functional Capacity Screen (FCS) dated 11-9-12 recorded Resident #444 independent with toileting, transfer, walking/mobility, eating, cognition, communication required physical assistance with bathing, dressing, management of medications, bladder incontinence experienced impaired vision and falls/unsteadiness.

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S3261	Continued From page 23 The annual FCS dated 10-28-13 recorded Resident independent with walking/mobility, eating, communication, required supervision with transfer, required physical assistance with bathing, dressing, toileting, management of medications, bladder incontinence, experienced short-term memory loss, memory recall, falls/unsteadiness and impaired vision. The Negotiated Service Agreement dated 11-1-13 recorded staff to assist with shower, dressing, and toileting. Certified Staff or Licensed Nurse to administer medications. The Resident Service Plan (RSP) dated 8-19-13 recorded Resident required staff to administer medications, assist with dressing, bathing, and getting ready for bed. The RSP dated 5-4-14 recorded medications administered by staff, keeps aspirin 81 milligrams at bedside to take by self. Staff to assist with hearing aides, assist with dressing, bathing, assist to bathroom at night, incontinent of bladder control and toilet four times a day as needed and help with transfers to commode, spouse assist Resident to dining room and Resident can go short distance by self. Must encourage to activities/exercise three times a week. Quarter side rails on bed for repositioning along with trapeze bar. Assist with getting ready and getting into bed. Assist to bath room at night. The Resident Care Notes (RCN) recorded the following: 4-29-13 at 4:00 p.m., Resident slid off side of bed during transfer from wheelchair to bed. Resident did not hit head or back. Resident reached for object on bedside table and slid off bed. No complaints of pain. Licensed Nurse C.	S3261		

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S3261	Continued From page 24 The notes lacked documentation of action taken. 6-1-13 (no time) Resident was sitting on side of bed and reached for object on bedside table, feet slipped on rug and slid down to the floor. Stated did not hit head. Two person transfer to bed. Spouse is gone on outing. Licensed Nurse C. The notes lacked a time, action taken, and results of actions taken. 9-26-13 11:45 a.m. Resident attempted to transfer from wheelchair to bed without assistance and slipped to floor. Stated was fine. Assisted up times two staff to wheelchair. At 3:30 p.m. received order for physical therapy evaluation and treatment. Licensed Nurse C. The notes lacked documentation of assessment, actions taken, and results of actions taken. 12-7-13 at 6:50 p.m. Found Resident on floor sitting by bathroom. Resident said slid down and was not hurt. Called (Licensed Nurse B) on call. Certified Staff G. The notes lacked documentation of actions taken and results of actions taken. 12-10-13 1:45 p.m. Complained of pain in left hip and lower back. Stated he/she slid down to the floor and his/her back and left hip really hurting today. The clinic was telephoned for the physician to call back. Licensed Nurse C. The notes lacked documentation of nursing assessment. 12-10-13 4:00 p.m. Continued with back pain and left side hip pain. Difficult with breathing with	S3261		

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complaint of pain. Left hip hurts. B/P 160/84, P 65, R 18, T 98.6. Telephoned the physician and left message. Licensed Nurse C.

12-10-13 4:50 p.m. Received a telephone call from clinic. Described signs and symptoms including left side and hip pain, unable to take a deep breath without encouragement. Tylenol 500 milligrams two tablets administered. An appointment set for 12-11-13 at 2:00 p.m. with physician. Notified Resident. Licensed Nurse C.

12-10-13 5:05 p.m. Clinic staff called stating Resident ' s appointment will need to be rescheduled. The physician will return to work on 12-16-13. Licensed Nurse C.

Notes lacked documentation of signs/symptoms, results of actions taken for pain management from 12-10-13 5:50 p.m. until 12-12-13 when resident seen by Advanced Practice Registered Nurse and received xray showing fractured rib.

2-4-14 11:30 a.m. Resident complained of left side below ribcage pain. B/P 148/86, P 62, T 97.5, R 24. Licensed Nurse D notified. Signed Certified Staff F.

Notes lacked documentation of actions taken and results of actions taken for rib pain.

Record lacked additional notes until 3 -5- 14 including signs and symptoms of illness that resulted in hospitalization, date and time resident left facility for hospitalization.

3-5-14 (no time) Resident had stay at Heart Hospital for stent placement in abdomen and right leg. Licensed Nurse B.

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S3261	Continued From page 26 3-6-14 (no time) Returned to facility stable condition and vital signs with in normal limits. Licensed Nurse B. Next entry in notes on 3-10-14 at 10:00 a.m. Resident had wheezing with diminished breath sounds in both lungs. Appointment with physician tomorrow. Licensed Nurse B. 3-11-14 2:00 p.m. Resident to physician office and admitted to hospital. Licensed Nurse B. 3-13-14 2:30 p.m. Returned from hospital. New orders received and noted. Stable conditions vital signs B/P 120/70, P 83, R 24, T 97.3. Licensed Nurse B. The notes lacked documentation of nursing assessment and results of actions taken from new orders. 4-21-14 1:00 p.m., Resident complained of not feeling well. Resident is coughing. B/P 140/60, P 90, R 24, T 100.3. Licensed Nurse D notified. Certified Staff F. The notes lacked documentation of nursing assessment, actions taken and results of actions taken. For Residents #555 and #444, the operator failed to ensure documentation of all incidents, signs/symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action taken.	S3261		