| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| COMFORT CARE HOMES INC #557 | 557 N ARMOUR ST WICHITA, KS 67218 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of an abbreviated survey of the above home plus facility for the investigation of complaint #77717 on 8/4/14, 8/5/14, 8/6/14, 8/7/14, 8/11/14, and 8/12/14. | S 000 | | |
| S5026 SS=D | 26-42-101 (f) (1) Staff Treatment of residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-101(f)(1)(B)<br><br>The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#3) of 3 residents sampled, the operator/licensed practical nurse (LPN) failed to ensure the resident was not subjected to neglect when the operator/LPN neglected to perform a timely assessment of resident, neglected to notify the resident's primary care physician, and neglected to seek immediate medical care for resident when resident was found to have maggots in wound.<br><br>Findings included: | S5026 | | |

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

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| S5026 | Continued From page 1<br>- Record review for resident #3 revealed an admission date of 7/11/11 and diagnoses of dementia, syncope, and hypertension.<br><br>The annual functional capacity screen dated 7/1/14 indicated the resident was unable to perform medical treatments and experienced impaired short and long-term memory, decision making ability, and memory recall.<br><br>The health care service plan dated 7/1/14, developed by operator/LPN, documented facility staff members to provide wound care to right ear of "cleanse/apply ointment and dressing daily." Additional notes section contained documentation by operator/LPN that resident was a smoker, sat outside frequently, dressing frequently came off due to drainage and location of wound, and that resident would remove dressing.<br><br>The negotiated service agreement dated 7/1/14 documented right ear--clean, apply ointment and dressing-- provided by facility staff.<br><br>Review of the resident's electronic medical record revealed nurse's notes documentation on 1/21/14 by registered nurse #B that resident #3 developed an open area with drainage behind the right ear that appeared to be a ruptured boil. On 1/22/14 registered nurse #B documented implementation of physician's order to culture wound and begin wound care with dressing changes. Registered nurse #B recorded frequent assessments that described the wound bed as filling in with beefy red tissue and the size of a quarter (2.5 centimeter) with minimal drainage. On 2/21/14 registered nurse #B recorded the wound was not healing and primary care physician contacted and on 2/24/14 documented application of warm moist pack to wound 4 times a day as ordered by | S5026 | | |

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| S5026 | Continued From page 2 | S5026 | | |

the physician. On 2/26/14 registered nurse #B recorded wound bed is a soft black area, with reddish-brown drainage, and continues to be the size of a quarter.

The nurse's notes lacked further documentation regarding the presence of the wound until LPN #D documented on 6/23/14 at 4:06 a.m. that a certified medication aide (CMA) contacted the nurse to report odor from wound and at times dressing soaked with red fluid. LPN #D documented he/she instructed CMA to cleanse area and apply appropriate dressing until nurse can be notified in the a.m.

The record lacked an entry 6/23/14 of a nursing assessment of the wound and consultation with primary care physician that wound drainage had increased and drainage now had an odor.

The nurse's notes lacked subsequent documentation by licensed nurses of nursing assessments of the resident and the resident's wound and consultation with the resident's primary care physician.

At 1:57 p.m. on 7/20/14,the operator/LPN documented " Resident continues with wound behind RT (right) ear -- determined by PCP (primary care physician) to be skin cancer - - family had elected to not treat - - call was placed to (physician's) office in past after speaking with family for approval requesting to have home health to care for wound. Dr. did not feel was needed as no treatment being done other than dressing change and could be maintained by (facility) staff - - area has increased in size and drains - - size and area are difficult to apply dressing - - dressing frequently comes loose or resident will at times remove. Caregiver reported

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| S5026 | Continued From page 3 | S5026 | | |

at 2356 (11:56 p.m.) on 7/19/14 that previous caregiver reported (he/she) had changed dressing but dressing had come loose - --that caregiver went to change dressing to a clean dressing and observed what (he/she) believed to be maggots- --reported area has a lot of bleeding and draining - - dressing was applied - --Caregiver working today assisted resident with showering and cleaned wound out - --This nurse then assessed resident and did note maggots in wound- - resident frequently sits outside as (he/she) is a smoker." Operator/LPN documented that he/she notified resident's family member that resident needed to be seen by primary care physician due to the presence of maggots in the resident's wound. Operator/LPN did not contact the resident's primary care physician to report a change in the resident's health status.

At 3:34 a.m. on 7/21/14, LPN #D documented he/she assessed the wound that was red with red fluid leaking into hair and surrounding skin. Resident stated area was tender. Nurse documented cleansing wound with normal saline, covered with gauze and transparent dressing.

At 4:49 p.m. on 7/21/14, operator/LPN documented he/she contacted the resident's family member again this afternoon. Family member reported physician's office called back but family member was going to have another family member meet at facility and they would transport resident to the emergency room. Operator/LPN did not contact the resident's primary care physician to report a change in the resident's health status.

At 9:32 a.m. on 7/22/14, operator/LPN documented that resident did not return from the

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| S5026 | Continued From page 4<br>emergency room visit.<br><br>A written statement by certified medication aide (CMA) #E on 8/5/14 recorded he/she came to work at 11:00 p.m. on 7/19/14, checked on resident #3 at 11:30 p.m., and observed dressing was off. CMA #E recorded that he/she observed maggots in the wound and called the nurse who instructed the CMA to put on a dressing. CMA #E recorded that at 4:00 a.m. (7/20/14) he/she observed that resident had removed the dressing and wound was bleeding. CMA #E called the nurse again and was told to put another dressing on the wound. CMA #E recorded that he/she gave report to the next shift that nurse would be in to see what else needed to be done.<br><br>A written statement by CMA #F on 8/5/14 recorded that he/she came to work at 7:00 a.m. on 7/20/14 and resident was still in bed. CMA #E recorded that he/she checked on resident a little later and ear (wound) was bleeding " way more than usual. " CMA #E took resident to the shower to clean the blood off and CMA #E observed maggots in the wound. CMA #E recorded that he/she applied a new dressing but the dressing would not stay on because of the bleeding. CMA #E then called the nurse to let the nurse know " it was pretty bad. " Nurse arrived about noon with more dressings.<br><br>At 10:30 a.m. on 8/6/14, the operator/LPN stated he/she was the nurse on call 7/19/14 and 7/20/14 and received phone calls from CMA #E at 11:56 p.m. on 7/19/14 and 4:00 a.m. 7/20/14 and from CMA #F the morning of 7/20/14 regarding changes in the resident's wound and did not come to assess the resident until noon 7/20/14. Operator/LPN confirmed he/she did not call the resident's primary care physician when he/she | S5026 | | |

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| S5026 | Continued From page 5<br>became aware of the resident's change in condition and did not seek immediate medical care for the resident.<br><br>On 8/5/14 during a phone interview, the resident's family member stated that resident required hospitalization on 7/21/14 for treatment of the wound. The family member stated that the wound care team cleaned the wound but could not remove all the maggots so resident required surgery for this and to remove the tumor and part of ear lobe. The family member stated he/she received a call from the operator/LPN on 7/20/14 and was informed of maggots in wound. Family member wanted resident to be taken to the emergency room at that time and operator/LPN " begged me not to take" (resident #3) to emergency room. Follow-up phone interview on 8/6/14, the family member stated he/she was unable to get an appointment with the primary care physician on 7/21/14 and another family member transported resident to the emergency room on 7/21/14.<br><br>Telephone interview at 12:00 p.m. on 8/6/14 with the registered nurse, director of resident care. The director stated he/she received a phone call from the operator/LPN on 7/20/14 and he/she instructed the operator/LPN to notify the resident's primary care physician and family and explain to them that wound was more than facility could handle and resident needed to go to the emergency room or minor emergency today or at the very least be seen by primary care physician in the morning.<br><br>The operator/LPN failed to ensure resident #3 was not subjected to neglect when the operator/LPN neglected to perform a timely assessment of resident, neglected to notify the | S5026 | | |

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| S5026 | Continued From page 6<br>resident's primary care physician, and neglected to seek immediate medical care for resident when resident was found to have maggots in wound. | S5026 | | |
| S5155 SS=G | 26-42-204 (a) Health Care Services<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-204(a)<br><br>The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#3) of 3 residents sampled, the operator/licensed practical nurse (LPN) failed to provide and coordinate necessary health care services that met the need of the resident with an open wound. The wound increased in size from 2.5 centimeters (cm) to 5.0 cm and wound became infested with maggots. Resident required hospitalization and surgery to remove imbedded maggots and to treat the wound.<br><br>Based on record review and interview for 1 (#2) of 3 residents sampled, the operator/LPN failed to provide and coordinate the provision of necessary health care services for monitoring signs and | S5155 | | |

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| S5155 | Continued From page 7<br>symptoms of hypoglycemia and hyperglycemia.<br><br>Findings included:<br><br>- Record review for resident #3 revealed an admission date of 7/11/11 and diagnoses of dementia, syncope, and hypertension.<br><br>The annual functional capacity screen dated 7/1/13 indicated the resident was unable to perform management of medical treatments and experienced impaired short and long-term memory, decision making ability, and memory recall<br><br>The negotiated service agreement and health care service plan dated 7/1/13, completed by LPN #C, lacked a description of services for the management of medical treatments and lacked revision to include a description of services for wound care after presence of wound identified 1/21/14.<br><br>The annual functional capacity screen dated 7/1/14, completed by the operator/LPN continued to indicate the resident was unable to perform management of medical treatments and experienced impaired short and long-term memory, decision making ability, and memory recall.<br><br>The negotiated service agreement dated 7/1/14 documented right ear wound - clean, apply ointment and dressing -- provided by facility staff.<br><br>The health care service plan dated 7/1/14, developed by operator/LPN, documented wound care to right ear of " cleanse/apply ointment and dressing daily." Additional notes section contained documentation by operator/LPN that | S5155 | | |

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| S5155 | Continued From page 8 | S5155 | | |

resident was a smoker, sat outside frequently, dressing frequently came off due to drainage and location of wound, and that resident would remove dressing.

The negotiated service agreement and health care service plan lacked a description of services to maintain the dressing on the wound, to ensure wound was covered with a dressing when the resident went outside, and signs and symptoms of infection that staff were to report to licensed nurse.

The record contained written primary care physician's order for wound care beginning on 1/22/14 that consisted of keep wound clean; apply polysporin (antibiotic) ointment, and gauze dressing to wound behind resident's right ear. On 2/24/14, the medical care provider ordered warm compresses 4 times a day for 15 minutes to wound. Primary care physician evaluated the resident on 3/6/14 and ordered wound care 1 to 2 times a day of clean wound, apply polysporin ointment and dressing; and monitor for and report signs and symptoms of infection.

Review of the resident's electronic medical record revealed nurse's notes documentation on 1/21/14 by registered nurse #B that resident #3 developed an open area with drainage behind the right ear that appeared to be a ruptured boil. On 1/22/14 registered nurse #B documented implementation of physician's order to culture wound and begin wound care with dressing changes. Registered nurse #B recorded frequent assessments that described the wound bed as filling in with beefy red tissue and the size of a quarter (2.5 centimeter) with minimal drainage. On 2/21/14 registered nurse #B recorded the wound was not healing and primary care physician contacted and

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| S5155 | Continued From page 9 | S5155 | | |

on 2/24/14 documented application of warm moist pack to wound 4 times a day as ordered by the physician. On 2/26/14 registered nurse #B recorded wound bed is a soft black area, with reddish-brown drainage, and continues to be the size of a quarter.

The nurse's notes lacked further documentation regarding the presence of the wound until LPN #D documented on 6/23/14 at 4:06 a.m. that a certified medication aide (CMA) contacted the nurse to report odor from wound and at times dressing soaked with red fluid. LPN #D documented he/she instructed CMA to cleanse area and apply appropriate dressing until nurse can be notified in the a.m.

The record lacked an entry of a nursing assessment and treatment of the wound on 6/23/14.

The nurse's notes lacked subsequent documentation by licensed nurses of nursing assessments of the resident and the resident's wound; instruction to CMAs providing wound care; and consultation with the resident's primary care physician.

At 1:57 p.m. on 7/20/14,the operator/LPN documented " Resident continues with wound behind RT (right) ear -- determined by PCP (primary care physician) to be skin cancer - - family had elected to not treat - - call was placed to (physician's) office in past after speaking with family for approval requesting to have home health to care for wound. Dr. did not feel was needed as no treatment being done other than dressing change and could be maintained by (facility) staff - - area has increased in size and drains - - size and area are difficult to apply

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dressing - - dressing frequently comes loose or resident will at times remove. Caregiver reported at 2356 (11:56 p.m.) on 7/19/14 that previous caregiver reported (he/she) had changed dressing but dressing had come loose - --that caregiver went to change dressing to a clean dressing and observed what (he/she) believed to be maggots- --reported area has a lot of bleeding and draining - - dressing was applied - --Caregiver working today assisted resident with showering and cleaned wound out - --This nurse then assessed resident and did note maggots in wound- - resident frequently sits outside as (he/she) is a smoker." Operator/LPN documented that he/she notified resident's family member that resident needed to be seen by primary care physician due to the presence of maggots in the resident's wound.

Operator/LPN did not contact the resident's primary care physician to report a change in the resident's health status.

At 3:34 a.m. on 7/21/14, LPN #D documented he/she assessed the wound that was red with red fluid leaking into hair and surrounding skin. Resident stated area was tender. Nurse documented cleansing wound with normal saline, covered with gauze and transparent dressing.

At 4:49 p.m. on 7/21/14, operator/LPN documented he/she contacted the resident's family member again this afternoon. Family member reported physician's office called back but family member was going to have another family member meet at facility and they would transport resident to the emergency room.

Operator/LPN did not contact the resident's primary care physician to report a change in the

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| S5155 | Continued From page 11 | S5155 | | |

resident's health status.

At 9:32 a.m. on 7/22/14, operator/LPN documented that resident did not return from the emergency room visit.

During an ongoing interview beginning at 12:20 p.m. on 8/5/14, operator/LPN stated he/she became the nurse responsible for the supervision and implementation of the resident's health care service plan beginning at the time registered nurse #B ended employment at the end of February 2014. Operator/LPN stated resident had a wound that was a skin cancer and family did not want aggressive treatment of the cancer but wanted wound care provided. Operator/LPN stated he/she assessed the resident's wound and provided the wound care one time a week. Operator/LPN stated wound assessments were to be documented in the nurse's notes and dressing changes were documented on the monthly medication administration record. By interview and review of the resident record and electronic medical record with the operator/LPN he/she confirmed he/she did not document nursing assessments of the resident and the resident's wound since becoming the nurse responsible for the resident's health care services at the end of February 2014. By interview and review of the March, April, May, June, and July 2014 medication administration records with the operator/LPN he/she confirmed he/she only documented providing wound care on 4/29/14 and 6/18/14. Operator/LPN stated he/she verbally told CMAs to provide daily wound care as written on health care service plan. Operator/LPN confirmed he/she did not demonstrate proper wound care to CMAs or observe each CMA perform the wound care. Operator/LPN stated he/she monitored CMAs

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performance by observing if resident's wound was dressed when he/she was in the facility and if dressing not in place, Operator/LPN would replace or instruct CMA to do this.

A written statement by CMA #E on 8/5/14 recorded he/she came to work at 11:00 p.m. on 7/19/14, checked on resident #3 at 11:30 p.m., and observed dressing was off. CMA #E recorded that he/she observed maggots in the wound and called the nurse who instructed the CMA to put on a dressing. CMA #E recorded that at 4:00 a.m. (7/20/14) he/she observed that resident had removed the dressing and wound was bleeding. CMA #E called the nurse again and was told to put another dressing on the wound. CMA #E recorded that he/she gave report to the next shift that nurse would be in to see what else needed to be done.

A written statement by CMA #F on 8/5/14 recorded that he/she came to work at 7:00 a.m. on 7/20/14 and resident was still in bed. CMA #E recorded that he/she checked on resident a little later and ear (wound) was bleeding " way more than usual. " CMA #E took resident to the shower to clean the blood off and CMA #E observed maggots in the wound. CMA #E recorded that he/she applied a new dressing but the dressing would not stay on because of the bleeding. CMA #E then called the nurse to let the nurse know " it was pretty bad. " Nurse arrived about noon with more dressings.

At 10:30 a.m. on 8/6/14, the Operator/LPN stated he/she was the nurse on call 7/19/14 and 7/20/14 and received the phone calls from CMA #E and CMA #F and instructed each CMA to clean and dress the wound and he/she would follow-up. Operator/LPN stated he/she arrived at the facility

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| S5155 | Continued From page 13<br><br>around 12:00 p.m. on 7/20/14 and assessed the wound. Operator/LPN stated he/she then notified family member by phone on 7/20/14 to take resident to primary care physician on 7/21/14 due to maggots in the resident's wound. Operator/LPN stated he/she called the family member again on 7/21/14 and family member decided to take resident to the emergency room 7/21/14. Operator/LPN confirmed he/she received the first phone call at 11:56 p.m. on 7/19/14 and 4:00 a.m. on 7/20/14, and during the morning of 7/20/14 regarding changes in the resident's wound and did not come to assess the resident until noon 7/20/14. Operator/LPN confirmed he/she did not call the resident's primary care physician when he/she became aware of the resident's change in condition.<br><br>On 8/5/14 during a phone interview, the resident's family member stated that resident required hospitalization on 7/21/14 for treatment of the wound. The family member stated that the wound care team cleaned the wound but could not remove all the maggots so resident required surgery for this and to remove the tumor and part of ear lobe. Family member stated that primary care physician saw resident in March of 2014 and instructed facility nurse to keep the wound clean, apply a topical antibiotic ointment, and keep dressing on wound. Family member stated that every time he/she visited resident at the facility there was no dressing covering wound. Facility staff told the family member that resident had removed the dressing. Family member stated he/she talked with a facility nurse who stated they would find a dressing that would stay in place. The family member stated he/she received a call from the operator/LPN on 7/20/14 and was informed of maggots in wound. Family member wanted resident to be taken to the emergency | S5155 | | |

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room at that time and operator/LPN " begged me not to take" (resident #3) to emergency room. Follow-up interview with the family member on 8/6/14 who stated he/she called the primary care physician's office at 9:10 a.m. on 7/21/14 and received a return call from someone at the office who instructed for resident to be seen by a dermatologist on 7/22/14. Family member stated he/she did not want to wait that long for resident to receive treatment. Family member stated he/she received call from operator/LPN on 7/21/14 to ask if resident would be seen by a physician on 7/21/14. Family member asked operator/LPN if facility could transport in their van since resident could not get into the family member's vehicle. Operator/LPN told family member that he/she would have to find out and call back. Family member stated that in the meantime he/she was able to contact a family member who could transport resident and family member decided resident would be taken to the emergency room.

Telephone interview at 12:00 p.m. on 8/6/14 with the registered nurse, director of resident care. The director stated he/she received a phone call from the operator/LPN on 7/20/14 regarding the presence of maggots in the resident's wound and instructed the operator/LPN to notify the resident's primary care physician and family member and explain to them that wound was more than facility could handle and resident needed to go to the emergency room or minor emergency today or at the very least be seen by primary care physician in the morning.

The hospital physician's history and physical dated 7/21/14 documented the presence of an ulcerated wound about 5 centimeters, located behind the right ear with foul smelling drainage

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with maggots in wound. The hospital discharge summary dated 7/30/14 documented the resident required cleaning of the wound of maggots with excision of wound and flap closure of the wound.

Resident #3 developed a wound behind the right ear on 1/21/14 that by 2/26/14 measured 2.5 cm with a black wound bed and reddish-brown drainage. By 7/21/14, the wound increased in size to 5 cm and became infested with maggots. The operator/LPN failed to provide and coordinate necessary health care services to ensure the wound remained covered; failed to monitor progression of wound; and failed to consult with resident's primary care physician for additional medical treatment. Resident #3 required hospitalization and surgery to remove imbedded maggots from the wound and to remove the tumor.

- Record review for resident #2 revealed an admission date of 6/25/14 and diagnoses of insulin dependent diabetes mellitus, hypothyroidism, hypertension, and memory loss.

The functional capacity screen dated 6/24/14 indicated the resident was unable to perform management of medications and medical treatments and experienced impaired short-term memory, long-term memory, and memory recall.

The negotiated service agreement dated 6/25/14 documented a home health agency provided insulin administration to the resident. The health care service plan dated 6/25/14 documented the home health agency performed blood sugar monitoring and insulin administration. The negotiated service agreement and health care service plan lacked a description of services for certified staff to monitor for signs and symptoms

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| S5155 | Continued From page 16<br>of hypoglycemia and hyperglycemia and to notify licensed nurse.<br><br>The resident's record lacked a medical care provider's order for facility certified or licensed staff members to perform blood sugar monitoring with a glucometer.<br><br>The resident's electronic medical record nurse's notes revealed an entry by LPN #D at 12:29 a.m. on 7/3/14 that caregiver obtained a glucometer reading of resident's blood sugar level of 36 at 10:50 p.m. on 7/2/14. LPN #D documented that he/she instructed certified medication aide (CMA) to give resident orange juice to drink. LPN #D documented follow-up blood sugar reading of 53 and at 11:57 p.m. on 7/2/14, LPN #D obtained blood sugar reading of 47. LPN #D documented that he/she paged on-call physician and instructed CMA to continue to observe blood sugar level and notify LPN #D if any changes while LPN #D awaited call from a physician.<br><br>At 11:55 a.m. on 8/5/14, operator/LPN confirmed the negotiated service agreement and health care service plan lacked a description of monitoring resident for signs and symptoms of hypoglycemia or hyperglycemia and instruction to CMAs of when to contact licensed nurse.<br><br>For resident #2, the operator/LPN failed to provide and coordinate the provision of necessary health care services for monitoring signs and symptoms of hypoglycemia and hyperglycemia. | S5155 | | |
| S5165 SS=F | 26-42-204 (e) Delegation of Duties<br><br>(e) A licensed nurse may delegate nursing procedures not included in the nurse aide or | S5165 | | |

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| S5165 | Continued From page 17<br>medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-204(e)<br><br>The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#3) of 3 residents sampled, the operator/licensed practical nurse (LPN) failed to appropriately delegate a nursing procedure to certified medication aides (CMAs) not included in the nurse aide or medication aide curriculums to medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.<br><br>Findings included:<br><br>- Record review for resident #3 revealed an admission date of 7/11/11 and diagnoses of dementia, syncope, and hypertension.<br><br>The electronic medical record nurse's notes documented that the resident developed a wound behind right ear on 1/21/14 that required daily dressing changes.<br><br>The annual functional capacity screen completed by the operator/LPN and dated 7/1/14 indicated the resident was unable to perform management of medical treatments and experienced impaired short and long-term memory, decision making ability, and memory recall.<br><br>The negotiated service agreement signed by the | S5165 | | |

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operator/LPN and dated 7/1/14 documented right ear - - clean, apply ointment and dressing - - provided by facility staff.

The health care service plan developed by the operator/LPN and dated 7/1/14 documented wound care to right ear of " cleanse/apply ointment and dressing daily. " Additional notes section contained documentation by operator/LPN that resident was a smoker, sat outside frequently, dressing frequently came off due to drainage and location of wound, and that resident would remove dressing.

Review of the electronic medical record nurse's notes revealed an entry by the operator/LPN at 1:57 p.m. on 7/20/14 that he/she received a call from certified medication aide (CMA) #E at 11:56 p.m. on 7/19/14 that he/she observed maggots in the wound behind resident's right ear and operator/LPN instructed CMA #E to apply a dressing to the wound. Operator/LPN documented the day shift CMA (#F) assisted resident with a shower to clean out the wound.

Review of the March, April, May, June, July, and August 2014 medication administration records revealed an entry for dressing changes to right ear wound with polysporin (topical antibiotic) ointment applied to affected area 1 or 2 times daily. The medication administration records contained initials of CMAs to indicate the wound treatment was completed.

Operator/LPN stated he/she verbally told CMAs to provide daily wound care as written on health care service plan. Operator/LPN confirmed he/she did not demonstrate proper wound care to CMAs or observe each CMA perform the wound care. Operator/LPN stated he/she monitored

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| S5165 | Continued From page 19<br>CMAs performance by observing if resident's wound was dressed when he/she was in the facility and if dressing not in place; operator/LPN would replace or instruct CMA to do this.<br><br>For resident #3, the operator/LPN failed to appropriately delegate a nursing procedure to CMAs not included in the nurse aide or medication aide curriculums to medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. | S5165 | | |
| S5251 SS=E | 26-42-105 (f) (11) Resident Records Documentation of Incidents<br><br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-105(f)(11)<br><br>The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 2 (#3 and #2) of 3 residents sampled, the operator/licensed practical nurse (LPN) failed to ensure the resident's medical record contained documentation of all symptoms and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.<br><br>Findings included:<br><br>- Record review for resident #3 revealed an | S5251 | | |

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| S5251 | Continued From page 20 | S5251 | | |

admission date of 7/11/11 and diagnoses of dementia, syncope, and hypertension.

The annual functional capacity screen dated 7/1/13 indicated the resident was unable to perform management of medical treatments and experienced impaired short and long-term memory, decision making ability, and memory recall

The negotiated service agreement and health care service plan dated 7/1/13, completed by LPN #C, lacked a description of services for the management of medical treatments and lacked revision to include a description of services for wound care after presence of wound identified 1/21/14.

The annual functional capacity screen dated 7/1/14, completed by the operator/LPN continued to indicate the resident was unable to perform management of medical treatments and experienced impaired short and long-term memory, decision making ability, and memory recall.

The negotiated service agreement dated 7/1/14 documented right ear wound - clean, apply ointment and dressing -- provided by facility staff.

The health care service plan dated 7/1/14, developed by operator/LPN, documented wound care to right ear of " cleanse/apply ointment and dressing daily." Additional notes section contained documentation by operator/LPN that resident was a smoker, sat outside frequently, dressing frequently came off due to drainage and location of wound, and that resident would remove dressing.

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| S5251 | Continued From page 21<br><br>The record contained written primary care physician's order for wound care beginning on 1/22/14 that consisted of keep wound clean; apply polysporin (antibiotic) ointment, and gauze dressing to wound behind resident's right ear. On 2/24/14, the medical care provider ordered warm compresses 4 times a day for 15 minutes to wound. Primary care physician evaluated the resident on 3/6/14 and ordered wound care 1 to 2 times a day of clean wound, apply polysporin ointment and dressing; and monitor for and report signs and symptoms of infection.<br><br>Review of the resident's electronic medical record revealed nurse's notes documentation on 1/21/14 by registered nurse #B that resident #3 developed an open area with drainage behind the right ear that appeared to be a ruptured boil. On 1/22/14 registered nurse #B documented implementation of physician's order to culture wound and begin wound care with dressing changes. Registered nurse #B recorded frequent assessments that described the wound bed as filling in with beefy red tissue and the size of a quarter (2.5 centimeter) with minimal drainage. On 2/21/14 registered nurse #B recorded the wound was not healing and primary care physician contacted and on 2/24/14 documented application of warm moist pack to wound 4 times a day as ordered by the physician. On 2/26/14 registered nurse #B recorded wound bed is a soft black area, with reddish-brown drainage, and continues to be the size of a quarter.<br><br>The nurse's notes lacked further documentation regarding the presence of the wound until LPN #D documented on 6/23/14 at 4:06 a.m. that a certified medication aide (CMA) contacted the nurse to report odor from wound and at times dressing soaked with red fluid. LPN #D | S5251 | | |

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documented he/she instructed CMA to cleanse area and apply appropriate dressing until nurse can be notified in the a.m.

The record lacked an entry of a nursing assessment and treatment of the wound on 6/23/14.

The nurse's notes lacked subsequent documentation by licensed nurses of nursing assessments of the resident and the resident's wound including signs of or lack of signs of healing.

At 1:57 p.m. on 7/20/14,the operator/LPN documented that resident continued to have a wound behind right ear that primary care physician determined to be skin cancer. Operator/licensed nurse documented that he/she had contacted resident's primary care physician in the past to request home health care to manage the wound but physician denied the request. Operator/LPN documented call received from caregiver 11:56 p.m. on 7/19/14 that dressing to wound was loose and caregiver changed dressing and observed what he/she believed to be maggots and area had a lot of bleeding and drainage. The operator/LPN's entry included that caregiver working today assisted resident with showering and cleaned wound out. Operator/LPN documented that he/she assessed the resident and did note maggots in wound.

The record lacked documentation with a date and time that operator/LPN consulted with the primary care physician requesting home health for wound management.

At 3:34 a.m. on 7/21/14, LPN #D documented he/she assessed the wound that was red with red

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| S5251 | Continued From page 23<br>fluid leaking into hair and surrounding skin. Resident stated area was tender. Nurse documented cleansing wound with normal saline, covered with gauze and transparent dressing. This entry lacked a complete assessment of the wound including wound measurements and a description of the wound bed and surrounding tissue.<br><br>At 4:49 p.m. on 7/21/14, operator/LPN documented family members of the resident transported resident to the emergency room.<br><br>At 9:32 a.m. on 7/22/14, operator/LPN documented that resident did not return from the emergency room visit.<br><br>During an ongoing interview beginning at 12:20 p.m. on 8/5/14, operator/LPN stated he/she assessed the resident's wound and provided the wound care one time a week. Operator/LPN stated wound assessments were to be documented in the nurse's notes and dressing changes were documented on the monthly medication administration record. By interview and review of the resident record and electronic medical record with the operator/LPN he/she confirmed he/she did not document nursing assessments of the resident and the resident's wound. By interview and review of the March, April, May, June, and July 2014 medication administration records with the operator/LPN he/she confirmed he/she only documented providing wound care on 4/29/14 and 6/18/14. Operator/LPN located a physician order for a wound culture dated 6/4/14 and stated this was the date he/she contacted the resident's physician to request an order for home health to provide wound management. Operator/LPN confirmed he/she did not document the | S5251 | | |

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| S5251 | Continued From page 24<br>consultation with the physician.<br><br>The registered nurse/director of resident care recorded in a written statement that he/she made a visit to the resident on 5/27/14 due to report from certified staff members that resident kept pulling the dressing off and wound sometimes had an odor. Director recorded that during visit dressing was dry and intact and no odor noted. The resident's record lacked documentation of the director's findings.<br><br>The operator/LPN failed to ensure the medical record for resident #3 contained documentation of all symptoms and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action.<br><br>- Record review for resident #2 revealed an admission date of 6/25/14 and diagnoses of insulin dependent diabetes mellitus, hypothyroidism, hypertension, and memory loss.<br><br>The functional capacity screen dated 6/24/14 indicated the resident was unable to perform management of medications and medical treatments and experienced impaired short-term memory, long-term memory, and memory recall.<br><br>The negotiated service agreement dated 6/25/14 documented a home health agency provided insulin administration to the resident. The health care service plan dated 6/25/14 documented the home health agency performed blood sugar monitoring and insulin administration. The negotiated service agreement and health care service plan lacked a description of services for certified staff to monitor for signs and symptoms of hypoglycemia and hyperglycemia and to notify licensed nurse. | S5251 | | |

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|---|---|---|---|
| | B087186 | A. BUILDING: _____ B. WING _____ | 08/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMFORT CARE HOMES INC #557 | 557 N ARMOUR ST WICHITA, KS 67218 |

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| S5251 | Continued From page 25<br><br>The resident's record lacked a medical care provider's order for facility certified or licensed staff members to perform blood sugar monitoring with a glucometer.<br><br>The resident's electronic medical record nurse's notes revealed an entry by LPN #D at 12:29 a.m. on 7/3/14 that caregiver obtained a glucometer reading of resident's blood sugar level of 36 at 10:50 p.m. on 7/2/14. LPN #D documented that he/she instructed certified medication aide (CMA) to give resident orange juice to drink. LPN #D documented follow-up blood sugar reading of 53 and at 11:57 p.m. on 7/2/14, LPN #D obtained blood sugar reading of 47. LPN #D documented that he/she paged on-call physician and instructed CMA to continue to observe blood sugar level and notify LPN #D if any changes while LPN #D awaited call from a physician.<br><br>The record lacked documentation by a licensed nurse of additional blood sugar readings per glucometer after resident experienced low blood sugar. The record lacked documentation of physician response and further treatment orders.<br><br>At 11:30 a.m. on 8/5/14, the director of resident care confirmed the resident record lacked documentation of action taken to treat resident's low blood sugar and the resident's response to treatment.<br><br>The operator/LPN failed to ensure the medical record of resident #2 contained documentation of symptoms of low blood sugar including the date, time of occurrence, action taken, and results of the action. | S5251 | | |

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| S5300 | Continued From page 26 | S5300 | | |
| S5300 SS=F | 26-42-205 (d) (1-2) Facility Administration of Medications<br><br>(d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met:<br>(1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility.<br>(2) Medication aides shall not administer medication through the parenteral route.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-205(d)<br><br>The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for all residents, the operator/licensed practical nurse failed to ensure certified medication aides and licensed nurses administered medications and treatments to residents according to professional standards of practice.<br><br>Findings included:<br><br>- The resident roster indicated the facility managed medications for the 6 residents. | S5300 | | |

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| S5300 | Continued From page 27<br><br>Review of the January, February, March, April, May, June, and July 2014 medication administration records for resident #3 revealed initials for each medication and treatment administered to the resident by certified medication aides and licensed nurses. Each medication administration record lacked a signature to identify each set of initials to show who administered the medications and treatments.<br><br>At 2:10 p.m. on 8/5/14, the director of resident care stated there should be a signature page in the medication administration notebook for certified medication aides and licensed nurses to sign to identify each person's initials. Resident care director unable to locate a signature page.<br><br>For all residents, the operator/licensed practical nurse failed to ensure certified medication aides and licensed nurses administered medications and treatments to residents according to professional standards of practice. | S5300 | | |
| S5320 SS=D | 26-42-205 (k) Medication Clinical Records<br><br>(k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the home manages the resident ' s medication or prefills medication containers or syringes contains the following documentation:<br>(1) A medical care provider ' s order for each medication;<br>(2) the name of the pharmacy provider of the resident ' s choice;<br>(3) any known medication allergies; and<br>(4) the date and the 12-hour or 24-hour clock time any medication is administered to the | S5320 | | |

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| S5320 | Continued From page 28<br>resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-42-205(k)(4)<br><br>The facility reported a census of 6 residents. The sample included 3 residents. Based on record review and interview for 1 (#2) of 3 residents sampled, the operator/licensed practical nurse (LPN) failed to ensure the resident's record contained the 12-hour or 24-hour clock time Humalog insulin was administered to the resident.<br><br>Findings included:<br><br>- Record review for resident #2 revealed an admission date of 6/25/14 and diagnoses of insulin dependent diabetes mellitus, hypothyroidism, hypertension, and memory loss.<br><br>The functional capacity screen dated 6/24/14 indicated the resident was unable to perform medication management.<br><br>The negotiated service agreement and health care service plan dated 6/25/14 documented the service of insulin administration by a home health agency.<br><br>Review of the 6/25/14 through 6/30/14 and the 8/1/14 through 8/31/14 medication administration records revealed an entry for Humalog 12 units 3 times a day 30 minutes after meals with times specified for administration as "A.M., Mid-day, P.M." The medication administration records | S5320 | | |

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| S5320 | Continued From page 29<br>lacked an entry of the actual clock time each dose of Humalog insulin was administered.<br><br>At 11:30 a.m. on 8/6/14, the operator/LPN stated a home health nurse injected each dose of insulin to resident #2. Operator/LPN confirmed the medication administration records for 6/25/14 through 6/30/14 and the doses administered so far in August 2014 lacked documentation of the actual clock time the home health nurse administered the Humalog insulin.<br><br>The operator/LPN failed to ensure the record for resident #2 contained the 12-hour or 24-hour clock time Humalog insulin was administered to the resident. | S5320 | | |