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	N019011	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTRIDGE	950 WEST ST JOHN ST GIRARD, KS 66743

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigation 73286 at the above named assisted living facility conducted on 5-20-14, 5-21-14 and 5-22-14.	S 000		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement 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; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d) The facility reported a census of 24 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview for 1 (#300) of 3 sampled residents, the operator failed to ensure the review and revision of the negotiated service agreement following a significant change in condition when resident began experiencing multiple falls. Findings included:	S3092		

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

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S3092	Continued From page 1 - Record review for resident #300 revealed admission on 6-27-13 with diagnoses Chronic Obstructive Pulmonary Disorder, Crohn's Disease, Anxiety, Anemia, Congestive Heart Failure and Hypertension. The Functional Capacity Screen (FCS) dated 10-1-13 recorded resident required supervision with bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Cognition: problems with short term memory and memory/recall. Current problems/risks identified: unsteadiness. The Negotiated Service Agreement (NSA) dated 10-1-13 recorded services for stand by assistance of 1 staff for bathing and dressing. Resident uses rolling walker. Independent with transfers and toileting. Transfers/walking/mobility/unsteadiness/walker: "No recent history of falls." Staff to administer medications, breathing treatments and oxygen. The NSA lacked interventions to address the resident's fall risk. Review of Fall Incident Reports revealed the following: 10-8-13 at 4:15 pm: "Fall. found lying on back with feet towards bathroom door and head towards kitchen table. Laceration 3 centimeters (cm) x 0.25 cm x 0.1 cm right hand. Unwitnessed. Resident was going to the bathroom. ambulating with walker and lost balance." 10-9-13 at 4:47 am: "Lying on back feet towards bathroom and head towards table. Unwitnessed. Resident said he/she was returning from	S3092		

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S3092	Continued From page 2	S3092		

bathroom, lost balance."
1-11-14 at 1:45 pm: "Fall. found lying between EZ chair and closet. Laceration 12 cm x 3 cm right arm. Unwitnessed. Resident said he/she was rushing out of chair to answer phone and lost balance."
1-15-14 at 6:12 am: "Fall. Sitting between kitchen, bedroom and bathroom doorway. Abrasion 8 cm x 6 cm. Unwitnessed. Resident stated was going to bathroom. lost balance and walker fell on him/her."
1-18-14 at 4:30 pm: "Fall. found on floor between chair and bed. Complained of Right rib pain. Unwitnessed. Resident stated was attempting to lay down covers to foot of bed and prepare for bed later in the evening and lost balance. Was using walker."
2-8-14 at 10:30 am: "Fall. Found with head between recliner and closet, feet towards kitchen, supine. Hematoma left knee. Stated was attempting to turn on oxygen machine while holding walker and walker rolled caused him/her to lose balance. Did not lock wheels of walker."
4-16-14 at 7:05 am: "Found sitting in front of recliner. laceration 12 cm x 1 cm left shin. Unwitnessed. Stated was putting on socks and slipped off the chair. Caught leg on brake of rolling walker."
5-19-14 at 7:00 am: "Fall. found sitting on floor in front of stool in bathroom. superficial lacerations. Unwitnessed. Stated was returning to bed after going to bathroom. Was ambulating without walker and no shoes."

Interview on 5-21-14 at 12:00 pm with administrative nurse A confirmed he/she did not review and revise the NSA when resident #300 began experiencing multiple falls.

For resident #300, the operator failed to ensure

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S3092	Continued From page 3 the review and revision of the negotiated service agreement following a significant change in condition when resident began experiencing multiple falls.	S3092		
S3095 SS=D	26-41-202 (f) NSA Refusal of Service (f) If a resident or the resident's legal representative refuses a service that the administrator or operator, the licensed nurse, the resident's medical care provider, or the case manager believes is necessary for the resident's health and safety, the negotiated service agreement shall include the following: (1) The service or services refused; (2) identification of any potential negative outcomes for the resident if the service or services are not provided; (3) evidence of the provision of education to the resident or the resident ' s legal representative of the potential risk of any negative outcomes if the service or services are not provided; and (4) an indication of acceptance by the resident or the resident's legal representative of the potential risk. . This REQUIREMENT is not met as evidenced by: KAR 26-41-202(f)(1)(2)(3)(4) The facility reported a census of 24 residents. The sample included e residents and 1 closed record review. Based on record review and interview for 1 (#300) of 3 sampled residents, the operator failed to ensure if a resident refuses a service, the operator, licensed nurse, resident's medical care provider or case manager believes	S3095		

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S3095	Continued From page 4	S3095		

is necessary for the resident's health and safety, the negotiated service agreement included 1) the service or services refused; 2) identification of any potential negative outcomes for the resident if the service or services are not provided: 3) evidence of the provision of education to the resident or the resident's legal representative of the potential risk of any negative outcomes if the service or services are not provided; and 4) an indication of acceptance by the resident or the resident's legal representative of the potential risk.

Findings included:

- Record review for resident #300 revealed admission on 6-27-13 with diagnoses Chronic Obstructive Pulmonary Disorder, Crohn's Disease, Anxiety, Anemia, Congestive Heart Failure and Hypertension.

The Functional Capacity Screen (FCS) dated 10-1-13 recorded resident required supervision with bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications and treatments. Cognition: problems with short term memory and memory/recall. Current problems/risks identified: unsteadiness.

The Negotiated Service Agreement (NSA) dated 10-1-13 recorded services for stand by assistance of 1 staff for bathing and dressing. Resident uses rolling walker. Independent with transfers and toileting. Staff to administer medications, breathing treatments and oxygen. The NSA lacked a refusal of services regarding resident's use of walker at all times and use of the call light to request assistance with all

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S3095	Continued From page 5	S3095		

transfers.

Review of Fall Incident Reports revealed the following:
10-8-13 at 4:15 pm: "Fall. found lying on back with feet towards bathroom door and head towards kitchen table. Laceration 3 centimeters (cm) x 0.25 cm x 0.1 cm right hand. Unwitnessed. Resident was going to the bathroom. ambulating with walker and lost balance. Told resident to use call light when he/she needs to transfer. weaker than normal today, cautioned not to ambulate without assistance and to use call light."
10-9-13 at 4:47 am: "Lying on back feet towards bathroom and head towards table. Unwitnessed. Resident said he/she was returning from bathroom, lost balance. Told resident to use call light."
1-11-14 at 1:45 pm: "Fall. found lying between EZ chair and closet. Laceration 12 cm x 3 cm right arm. Unwitnessed. Resident said he/she was rushing out of chair to answer phone and lost balance. Was ambulating without walker. Advised resident to take his/her time and always use walker."
1-15-14 at 6:12 am: "Fall. Sitting between kitchen, bedroom and bathroom doorway. Abrasion 8 cm x 6 cm. Unwitnessed. Resident stated was going to bathroom. lost balance and walker fell on him/her. Tole resident to push call light before going to bathroom and not to rush."
1-18-14 at 4:30 pm: "Fall. found on floor between chair and bed. Complained of Right rib pain. Unwitnessed. Resident stated was attempting to lay down covers to foot of bed and prepare for bed later in the evening and lost balance. Was using walker. Told resident to use call light for transfers."
2-8-14 at 10:30 am: "Fall. Found with head

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S3095	Continued From page 6	S3095		

between recliner and closet, feet towards kitchen, supine. Hematoma left knee. Stated was attempting to turn on oxygen machine while holding walker and walker rolled caused him/her to lose balance. Did not lock wheels of walker. Told resident: 1. lock brakes on walker. 2. to not use walker without assistance. 3. use call button. 4. get in wheelchair for greater mobilization."
4-16-14 at 7:05 am: "Found sitting in front of recliner. laceration 12 cm x 1 cm left shin. Unwitnessed. Stated was putting on socks and slipped off the chair. Caught leg on brake of rolling walker. Told resident to ask for help or sit further back on chair."
5-19-14 at 7:00 am: "Fall. found sitting on floor in front of stool in bathroom. superficial lacerations. Unwitnessed. Stated was returning to bed after going to bathroom. Was ambulating without walker and no shoes. Reminded resident to use walker and wear shoes with non-skid tread while ambulating."

Interview on 5-21-14 at 12:00 pm with administrative nurse A confirmed the NSA lacked a refusal of services in regard to resident's refusal to call for assistance before attempting to transfer, go to the bathroom and when ambulating.

Interview on 5-21-14 at 12:05 pm with resident #300 stated, "I get dizzy when I first get up and when I try to turn around it makes me dizzy." Resident wearing a call pendant necklace, confirmed he/she does use it "to call for help after I fall."

For resident #300, the operator failed to ensure the NSA included the services refused by the resident (assistance with transfers, toileting and

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S3095	Continued From page 7 ambulation); identification of any potential negative outcomes for the resident if those services were not provided; evidence of the provision of education to the resident of the potential risks if the services were not provided; and an indication of acceptance by the resident or the legal representative of the potential risks.	S3095		
S3215 SS=F	26-41-205 (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 facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not	S3215		

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S3215	Continued From page 8 administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 24 residents. The sample included 3 residents and 1 closed record review. Based on observation and interview, the operator failed to ensure all medications and biologicals are securely and properly stored in accordance with each manufacturer's recommendations and with federal and state laws and regulations. Licensed nurses and medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. Licensed nurse or medication aide shall not administer medications beyond the manufacturer's recommendations. Findings included: - Observation during entrance tour of facility on 5-20-14 at 12:45 pm revealed medication cart setting in front of nursing office unattended and unlocked. Four residents sitting in living room adjacent to unlocked cart. Surveyor sat in front cart for at least 5 minutes with no staff in the area. Interview on 5-20-14 at 12:50 pm with administrative nurse A confirmed the cart was unlocked.	S3215		

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S3215	Continued From page 9 The operator failed to ensure all medications and biologicals are securely stored in accordance with federal and state laws and regulations. Licensed nurses and medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. - Observation during entrance tour on 5-20-14 at 2:07 pm of medication refrigerator revealed one bottle of tuberculosis skin testing solution with open date of 3-29-14. Interview on 5-20-14 at 2:07 pm with administrative nurse A confirmed the TB solution "should have been discarded after 30 days" and removed the bottle. Administrative nurse A unable to state when the TB solution was last used. The operator failed to ensure all medications and biologicals were properly stored in accordance with each manufacturer's recommendations and not administered beyond the manufacturer's recommendations.	S3215		