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GRAN VILLAS PITTSBURG	1004 E CENNTENIAL PITTSBURG, KS 66762

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey and investigation of complaint #74230 of the above assisted living facility on 5/5/14, 5/6/14, and 5/7/14.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 2 (#351 and #350) of 3 residents sampled, the operator/registered nurse (RN) failed to ensure the development of a written negotiated service agreement (NSA) for each resident based on the resident's functional	S3085		

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

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capacity screening that included a description of services for the residents at risk for falls.

Findings included:

- Record review for resident #351 revealed an admission date of 9/23/13 and diagnoses of attention deficit disorder, hyperactivity, and history of brain tumor. The functional capacity screen dated 9/23/13 indicated the resident required physical assistance with bathing, dressing, toileting, transferring and mobility; experienced impaired short-term memory, long-term memory, decision making, and memory recall; and was at risk for falls.

The nurse's notes contained documentation by the operator/RN as follows:

10/22/13 Resident fell when transferring from wheelchair to bed without assistance.

12/01/13 Resident fell when trying to pick up cell phone from the floor.

12/18/13 Resident fell when leaning forward in wheelchair.

1/12/14 Resident fell from wheelchair when leaning forward to pick up lighter.

1/21/14 Resident slid out of wheelchair when trying to pick up a dime from the ground.

5/6/14 Resident fell out of wheelchair on 3/19/14 while reaching for an item.

5/6/14 Resident fell on 5/2/14 when trying to wipe something off wheelchair.

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Review of the NSA dated 9/23/13 revealed the lack of a description of services related to the resident's risk for falls.

During an interview at 1:00 p.m. on 5/6/14, the operator/RN confirmed the NSA lacked a description of services related to the resident's risk for falls.

The operator/RN failed to ensure the development of a written NSA for resident #351 based on the resident's functional capacity screening that included a description of services for the resident's risk for falls.

- Record review for resident #350 revealed an admission date of 1/18/14 and diagnoses of Parkinson's disease and recurrent falls. The functional capacity screen dated 1/18/14 indicated the resident required physical assistance with bathing, dressing, toileting, and transferring; experienced impaired short-term memory; and was at risk for falls.

The record contained documentation by certified medication aides (CMA) as follows:

2/27/14 CMA #B documented on a "Notification of Incident/Medication Error" form that resident fell in room.

3/29/14 CMA #F documented on a "Physician Fax Sheet" that resident lost balance and fell backwards in resident's room.

Review of the NSA dated 1/18/14 revealed the lack of a description of services related to the resident's risk for falls.

During an interview at 1:00 p.m. on 5/6/14, the

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S3085	Continued From page 3 operator/RN confirmed the NSA lacked a description of services related to the resident's risk for falls. The operator/RN failed to ensure the development of a written NSA for resident #350 based on the resident's functional capacity screening that included a description of services for the resident's risk for falls.	S3085		
S3171 SS=F	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 27 residents. The sample included 3 residents. Based on record review and interview for 3 (#352, #351, and #350) of 3 residents sampled, the operator/registered nurse (RN) failed to ensure health care services were provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #352 revealed an admission date of 6/1/12 and diagnoses of epilepsy, anxiety, and joint pain. The functional capacity screen dated 6/1/13 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and management of medications and treatments;	S3171		

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supervision with mobility; experienced impaired short-term memory, decision making, and memory recall; and was at risk for falls. The negotiated service agreement dated 6/1/13 documented services provided by facility staff members of physical assistance with bathing, dressing, toileting, and transferring; supervision of mobility in motorized chair; management of medications and treatments, and reorient as needed. The negotiated service agreement contained documentation by the operator/RN related to resident's risk for falls for staff members to encourage resident to call and wait for assistance and to use grabber to pick items up from floor.

The record contained documentation that the resident experienced a fall on 7/20/13 as evidenced by documentation completed by certified medication aide (CMA) as follows:

"Notification of Incident/Medication Error" form completed and signed by CMA #B on 7/21/14 that resident fell in bathroom when transferring to toilet on 7/20/13 at 7:30 p.m. CMA documented the resident's vital signs and nurse notification at 7:35 p.m. CMA circled "Yes" that nurse talked resident through active range of motion and full range of motion of all extremities without pain or discomfort. CMA documented family notified of resident's fall at 7:40 p.m. on 7/20/13 and left message on answering machine. CMA documented physician notified on 7/20/13. Operator /RN documented contact made with family on 7/21/13.

CMA #B completed a "Physician fax Sheet" 7/21/13 that documented resident's fall when transferring to toilet. CMA documented "ROM [range of motion] done. No injuries at this time."

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S3171	Continued From page 5 The record lacked documentation that the licensed nurse assessed the resident and consulted with the resident's physician after the resident experienced the fall. The record contained documentation that the resident experienced a fall on 8/10/13 as evidenced by documentation completed by certified medication aide (CMA) as follows: CMA #C documented on 8/10/13 that he/she was contacted at 6:24 p.m.by staff on duty that resident fell and hit head. Staff called the operator/RN "who walked them through ROM." Resident was sent to hospital for evaluation at 6:50 p.m. CMA #D completed a "Physician Fax Sheet" and faxed to resident's physician 8/10/13 that resident fell out of wheelchair at 6:20 p.m. and was sent to hospital at 6:55 p.m. CMA #D documented "Abrasion on left side of forehead; some rug burns on left cheek/side of face." The record contained "Nursing Assessment" forms completed by licensed nurse #E dated 8/11/13 and 8/12/13 that lacked the time of each assessment. The record lacked documentation that the licensed nurse assessed the resident at the time of the fall and when the resident returned from the hospital evaluation. The record lacked documentation that the licensed nurse consulted with the resident's physician after the resident experienced the fall. The record contained documentation that the resident experienced a fall on 2/22/14 as	S3171		

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evidenced by documentation completed by certified medication aide (CMA) as follows:

CMA #D completed a "Physician Fax Sheet" dated 2/22/14 and fax date of 2/22/14 that resident fell when attempting to walk unassisted. CMA #D documented no apparent injuries.

The record lacked documentation that the licensed nurse assessed the resident and consulted with the resident's physician after the resident experienced the fall.

At 4:55 p.m. on 5/5/14, the operator/RN stated that when a resident experienced a fall and he/she was not in the facility, the CMA called him/her and operator/RN talked resident through active range of motion. If resident was not in pain with range of motion then the CMA assisted resident up and CMA faxed the resident's physician and called resident's family member to notify of fall. Operator/RN confirmed he/she did not document his/her assessment of the resident, consultation with physician, outcome of consultation, and notification of the resident's family member.

The operator/RN failed to ensure health care services were provided to resident #352 by qualified staff in accordance with acceptable standards of practice.

- Record review for resident #351 revealed an admission date of 9/23/13 and diagnoses of attention deficit disorder, hyperactivity, and history of brain tumor. The functional capacity screen dated 9/23/13 indicated the resident required physical assistance with bathing, dressing, toileting, transferring and mobility; experienced impaired short-term memory, long-term memory,

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decision making, and memory recall; and was at risk for falls. The negotiated service agreement dated 9/23/13 documented the services provided by staff members of physical assistance with bathing, dressing, toileting, transferring, mobility, and management of medications and treatments.

The record contained documentation of resident's falls with physician notification by fax completed by a certified medication aide (CMA) as follows:

10/22/13 CMA #F completed a "Physician Fax Sheet" and faxed on 10/22/13 that resident fell when transferring from wheelchair to bed without assistance. CMA #F documented "Scrape on right knee." The record lacked documentation of licensed nurse consultation with the physician and family notification of the fall.

12/01/13 CMA #B completed a "Physician Fax Sheet " that resident fell when trying to pick up cell phone from the floor. CMA #B documented "Resident has a red nose on the tip of it." The record lacked documentation of licensed nurse consultation with the physician after the fall.

12/18/13 CMA #F completed a "Physician Fax Sheet" and faxed on 12/18/13 that resident leaned forward and fell from wheelchair "smashing glasses into face leaving a small cut on nose." The record lacked documentation of licensed nurse consultation with the physician and family notification of the fall.

1/12/14 CMA #D completed a "Physician Fax Sheet" and faxed on 1/12/14 that resident slid out of wheelchair while attempting to re-enter building and fell onto left side. CMA #D documented "Lacerations on left hand and knee, hematoma on temple, abrasions to right and left knees and

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forehead." The record lacked documentation of licensed nurse consultation with the physician after the fall.

1/21/14 CMA #D completed a "Physician Fax Sheet" and faxed on 1/21/14 that resident slid out of wheelchair when trying to pick up a dime from the floor. CMA #D documented no apparent injuries. The record lacked documentation of licensed nurse consultation with the physician and family notification of the fall.

3/19/14 CMA #B completed a "Physician Fax Sheet" that resident fell out of wheelchair in the resident's room while reaching for an item. CMA #B documented resident had a rug burn on right knee and complained of arm pain. The form contained documentation that this was faxed to physician 3/19/14. The record lacked documentation of licensed nurse consultation with the physician and family notification of the fall.

At 1:15 p.m. on 5/6/14, the operator/RN confirmed CMAs faxed the resident's physician after the resident's falls with a description of injuries. Operator/RN confirmed he/she did not consult with resident's physician after the falls and did not always notify the resident's family member.

The operator/RN failed to ensure health care services were provided to resident #351 by qualified staff in accordance with acceptable standards of practice.

- Record review for resident #350 revealed an admission date of 1/18/14 and diagnoses of Parkinson's disease and recurrent falls. The functional capacity screen dated 1/18/14 indicated the resident required physical

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S3171	Continued From page 9 assistance with bathing, dressing, toileting, and transferring; experienced impaired short-term memory; and was at risk for falls. The negotiated service agreement dated 1/18/14 documented the services provided by staff members of physical assistance with bathing, dressing, toileting, transferring, and management of medications and treatments. The record contained a "Physician Fax Sheet" completed by certified medication aide #F and dated 3/29/14 that resident lost balance, fell backwards in resident's room, and received a "skinned elbow." The record lacked documentation of licensed nurse assessment and time of consultation with the physician. At 11:45 p.m. on 5/6/14, the operator/RN confirmed the CMA faxed the resident's physician after the resident's falls with a description of injury. Operator/RN confirmed the lack of a documented nursing assessment and consultation with the resident's physician. The operator/RN failed to ensure health care services were provided to resident #350 by qualified staff in accordance with acceptable standards of practice.	S3171		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place	S3211		

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S3211	Continued From page 10 the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 27 residents. The sample included 3 residents. Based on observation and interview for all residents receiving over-the-counter medications, the operator/registered nurse (RN) failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on the medication package. Findings included: - During tour of the medication room at 12:55 p.m. on 5/5/14, observed bottles of over-the-counter medications for residents in a cabinet. A resident's name was on each over-the counter medication package. Certified medication aide (CMA) #A stated CMAs labeled the medication packages with the resident's name. At 4:55 p.m. on 5/5/14, the operator/RN stated the CMA on duty at the time the over-the-counter medication was delivered to the facility placed the name of the resident on the medication package.	S3211		

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S3211	Continued From page 11 Operator/RN confirmed he/she did not label each over-the-counter medication package with the resident's full name. For all residents receiving over-the-counter medications, the operator/RN failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on the medication package.	S3211		