STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087221	A. BUILDING: _____ B. WING _____	C 06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED CARE HOME PLUS	5501 POLO DRIVE WICHITA, KS 67208

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S 000	INITIAL COMMENTS The following represent the findings of a complaint investigation 180862 at the above named Home Plus conducted on 06/19/23 and 06/20/23.	S 000		
S 135 SS=F	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(A)	S 135		

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

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S 135	Continued From page 1	S 135		

The facility reported a census of eight residents. Based on interview and record review the operator failed to ensure designated facility staff notified the legal representative or designated family member of an accident involving the resident that resulted in injury and has the potential for requiring a physician's intervention for residents (R)101, R102 and R103.

Findings included:

- Review of R101's medical record revealed she was admitted to the facility on 08/09/22 with diagnoses of dementia agitation and psychosis.

The 08/09/22 "Functional Capacity Screen" (FCS) documented R101 was unable to transfer and ambulate by herself.

The 08/09/22 "Negotiated Service Agreement" (NSA) documented staff were to encourage R101 to use her walker and had no recent falls.

Review of medical records failed to locate documentation that facility staff notified R101's daughter of falls involving R101 hitting her head resulting in an injury twice on 06/11/23 and that R101 was taken to the hospital.

A late entry "Nursing Note" dated 06/11/23 at 06:30 AM by Licensed Nurse (LN) C documented she was notified by Certified Medication Aide B that R101 had a fall resulting in a "goose egg bump" on the back of her head.

A late entry "Nursing Note" dated 06/11/23 at 10:30 PM by LN C documented CMA E called to

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inform her that R101 had an unwitnessed fall which resulted in bleeding from her nose and face. LN C instructed CMA E to call the Emergency Medical Service (EMS) and notify R101's family member and to document this was done.

A late entry "Nursing Note" dated 06/12/23 at 05:00 AM by LN C documented she contacted R101's family member to check on her status and was informed that CMA E never contacted her as instructed.

On 06/19/23 at 11:45 AM R101's family member stated the facility did not provide any notification of R101 falling on 06/11/23 or her being transferred to the hospital.

On 06/20/23 at 10:38 AM LN C stated there was no documentation R101's family member had been notified for her falls on 06/11/23.
The operator failed to ensure designated staff notified R101's family member of falls involving head injuries and being transferred to the hospital.

- Review of R102's medical record revealed she was admitted to the facility on 09/25/22.

The 03/06/23 FCS documented R102 required supervision with transfers and ambulation.

The 03/06/22 NSA documented R102 mobility assistance.

Review of R102's medical records revealed no documentation of a fall resulting in R102's hospitalization. There was no documentation of

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R102's durable power of attorney (DPOA) being notified of the fall or of the resulting hospitalization.

On 06/20/23 at 12:20 PM CMA B stated R102 had a fall sometime in March or April of 2023 which resulted in a hip replacement. CMA B acknowledged there was no documentation in the nursing notes concerning the fall.

The operator failed to ensure designated staff notified R102's DPOA of a fall resulting in R102 being transferred to the hospital.

- Review of R103's medical record revealed she was admitted to the facility on 09/01/21 with a diagnosis of neuropathy.

The 09/02/21 FCS documented R103 required physical assistance with transfers.

The 09/28/21 NSA documented staff to provide transfer and mobility assistance.

On 05/17/23 CMA D documented R103 had fallen in front of another resident's room and told staff she hit her head while falling resulting in an egg-sized bump on the back of her head.

There was no documentation that R103's DPOA was notified of the this fall or her subsequent transfer to the hospital.

The operator failed to ensure designated staff notified R103's DPOA of a fall resulting in R103 being transferred to the hospital.

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S5251	Continued From page 4	S5251		
S5251 SS=F	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (f) (11) The facility reported a census of eight residents. The sample included three abbreviated chart reviews. Based on record review and interview for three sampled residents (R)101, R102, and R103, the operator failed to ensure documentation on residents in accordance with accepted professional standards and practices including all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the action. Findings included: - Review of R101's medical record revealed she was admitted to the facility on 08/09/22 with diagnoses of dementia agitation and psychosis. The 08/09/22 "Functional Capacity Screen" (FCS) documented R101 was unable to transfer and ambulate by herself. The 08/09/22 "Negotiated Service Agreement" (NSA) documented staff were to encourage R101 to use her walker and had no recent falls.	S5251		

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S5251	Continued From page 5 An initial review of R101's medical records on 06/19/23 revealed no documentation concerning two falls occurring on 06/11/23. Late entry documentation was completed by Certified Medication Aide (CMA) D on 06/19/23 and Licensed Nurse (LN) C on 06/20/23. No follow-up documentation including neuro checks or accident reports were completed. On 06/19/23 at 01:53 PM CMA B stated R101 fell at 06:05 AM on 06/11/23. Stated she found R101 on the floor by the bathroom and noticed R101 had a goose-egg on the back of her head. CMA C stated R101 had another fall later during the night shift. On 06/20/23 at 10:38 AM LN C stated she expected a nursing note and an Accident/Incident report to be completed after each fall. LN C stated she instructed CMA D to complete these for the fall that occurred the evening of 06/11/23, but CMA D did not. The undated "Resident Records" policy documented, "Advanced Care Home Plus operator shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices ...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." The operator failed to ensure documentation for R101's care was in accordance with accepted professional standards and practices.	S5251		

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- Review of R102's medical record revealed she was admitted to the facility on 09/25/22.

The 03/06/23 FCS documented R102 required supervision with transfers and ambulation.

The 03/06/22 NSA documented R102 mobility assistance.

Review of R102's medical records revealed no documentation of a fall resulting in R102's hospitalization and hip replacement was completed. No Accident/Incident investigations were located in R102's medical records.

05/05/23 "Nurses Note" by LN C documented, "Staples removed from right lateral thigh from hip replacement. Incision healed, no open areas, redness or drainage present."

On 06/20/23 at 12:36 PM R102 stated she had a fall about two months prior at approximately 05:00 AM. R102 stated she walked to the bathroom and didn't turn on the light and she missed the toilet when she tried to sit down. R102 stated she had to have her hip replaced.

On 06/20/23 at 12:20 PM CMA B stated R102 had a fall sometime in March or April of 2023 which resulted in a hip replacement. CMA B acknowledged there was no documentation in the nursing notes concerning the fall and there was no accident/incident investigation completed.

The undated "Resident Records" policy documented, "Advanced Care Home Plus operator shall ensure the maintenance of a

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record for each resident in accordance with accepted professional standards and practices ...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."

The operator failed to ensure documentation for R102's care was in accordance with accepted professional standards and practices.

- Review of R103's medical record revealed she was admitted to the facility on 09/01/21 with a diagnosis of neuropathy.

The 09/02/21 FCS documented R103 required physical assistance with transfers.

The 09/28/21 NSA documented staff to provide transfer and mobility assistance.

On 05/17/23 CMA D documented R103 had fallen in front of another resident's room and told staff she hit her head while falling. R103 had an egg-sized bump on the back of her head.

On 05/17/23 LN C documented R103 had a fall and hit her head hard on the floor.

No follow-up documentation including neuro checks, Accident/Incident investigation with fall interventions were completed for the fall on 05/17/23.

On 06/20/23 at 12:13 PM CMA B stated R103 had a fall when she was walking to the bathroom while using her walker and hit her head. CMA B stated neurological follow-ups should be

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S5251	Continued From page 8 completed after a fall that involved the resident hitting their head. The undated "Resident Records" policy documented, "Advanced Care Home Plus operator shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices ...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." The operator failed to ensure documentation for R103's care was in accordance with accepted professional standards and practices.	S5251		