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	N046087	A. BUILDING: _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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 an abbreviated survey with complaint investigation 82773 conducted at the above named residential health care facility on 2-17-15, 2-18-15, 2-19-15, 2-23-15, 2-24-15, 2-25-15, and 2-26-15.	S 000		
S 135 SS=E	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)(A)(D)	S 135		

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

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S 135	Continued From page 1 The facility reported a census of 39 residents. The sample included 9 residents and 1 closed record review. Based on record review and interview for 3 (#2, #3, #7) of 9 sampled residents and 1 (#4) of 1 closed record, the administrator failed to ensure that designated facility staff informed the resident, consulted with the resident's physician and/or notified the resident's legal representative or designated family member upon occurrence of accidents involving the residents that resulted in injury or had the potential for requiring a physician's intervention; and/or made a decision to transfer the resident from the facility. Findings included: - Record review for resident #2 revealed admission on 2-10-15 with diagnoses Dementia, Aortic Stenosis, Hypertension, and Anemia. The functional capacity screen (FCS) dated 2-4-15 recorded resident required physical assistance with bathing, dressing and management of medications/treatments; independent with toileting, transfers, walking/mobility and eating. Usually continent of bladder ("dribbles urine'). Cognition: problems with short term memory, memory/recall and decision-making. No problems with communication. Current problems identified included impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 2-6-15 stated resident was independent with getting in/out of bed and required a reminder that it is bedtime and cueing to get ready for bed. Facility staff to give medication; staff to cue/remind of bath days and mealtimes. Resident identified as a moderate fall risk. Staff to monitor environment for fall hazards twice a day and report changes in	S 135		

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gait, balance, and level of consciousness or if resident falls. The nurse will complete a full re-assessment within 30 days and as needed for change of condition.
Nurse's Notes:
2-11-15 at 3:45 pm: "Resident witnessed walking with unsteady gait, lost balance and fell in hallway. Resident assessed and no visible injuries noted. Resident was noted leaning back and to the left. Resident assisted up into wheelchair with staff." Signed by licensed staff C. Per facility incident report, physician was notified on 2-11-15 at 3:45 pm. The record lacked documentation of notification of family member or legal representative.
2-11-15 at 7:40 pm: "Resident obtained a skin tear on left hand elbow. Care giver said he/she tried to fit on chair in hallway when he/she hurt self. Informed nurse on assisted living and attended him/her. Family member aware. (Vital signs recorded.) Resident denied pain at the moment. Resident assisted back to bed but very unstable. Walking when leaning on side. Will continue to monitor." Signed by certified staff G. The record lacked documentation of notification of physician or medical care provider.

Interview on 2-19-15 at 3:05 pm with licensed staff C confirmed the physician was not notified of either of the incidents on 2-11-15 and the observation from staff that resident was leaning and unstable with ambulation.

For resident #2, the administrator failed to ensure that designated facility staff consulted with the resident's physician when the resident experienced a change in condition and following an accident that had the potential for requiring a physician's intervention.

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S 135	Continued From page 3 - Record review for resident #3 revealed admission on 10-2-13 with diagnoses Dementia, Anxiety, Depression, Diabetes Mellitus, Hypertension and Hyperlipidemia. The functional capacity screen (FCS) dated 11-26-14 recorded resident required physical assistance with bathing, dressing, toileting, eating, and management of medications/treatments; independent with transfers, and walking/mobility. Occasionally incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness and impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 11-26-14 recorded the following services: Morning/Night care: Staff to remind resident that it is bedtime and cue to put on nightgown and get into bed. Dressing: assist with dressing daily. Bathing: Staff to remind of shower day, adjust shower, cue to undress and stop into shower. Scheduled courtesy checks: Check on resident at night but do not wake. Resident wakes up at times at night and becomes confused and at times believes that he/she is getting kicked out or that something has happened to children. Reassure. Dining: leaves the dining room frequently without eating. Cue to come back and eat. Toileting: Continent of bladder and stool. Fall risk: High Fall Risk. Keep room free of obstacles and clutter. Resident walks in hallways most of the time. Encourage resident to sit and rest. Assist resident with changing his/her pull up	S 135		

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as needed.
Transfer ability: independent transfer to and from bed, chair, laying, sitting, standing. Can tolerate distances and sustained activity.
Incontinence Care: Resident has pull ups. Resident would rather wear underwear and does take the pull up off. Resident has occasional incontinence of urine and does require assistance with changing with incontinent episodes.
Additions to NSA:
2-3-15: Fall in bistro. Skin tear to left elbow. No shoes on. Loose stool on clothes and floor. Ensure resident has on shoes.
2-13-15: Do not give resident ensure while he/she is walking. Have resident sit and drink it and sit with him/her. As you encourage resident to sit and rest, sit with him/her and talk calmly, have him/her hold a baby, a book or stuffed animal.

Nurse's Notes revealed the following:
2-9-15 at 7:15 am: "Resident assistant noted resident coming out of room with blood running down face. Blood noted on threshold to bathroom. Nurse applied pressure to 1 centimeter cut mid forehead and applied steri-strips. No other visible injuries noted. Nurse Practitioner notified. Resident brought to dining room." Signed by licensed staff C. The entry lacked documentation of notification of resident's legal representative.

Interview on 2-19-15 at 5:35 pm with licensed staff C stated he/she called resident's family member but was unable to find documentation. Confirmed the record lacked documentation of notification of the resident's legal representative.

For resident #3, the administrator failed to ensure that designated staff notified the resident's legal representative or designated family member upon

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S 135	Continued From page 5 occurrence on an accident involving the resident that resulted in injury. - Record review for resident #4 revealed admission on 12-29-14 with diagnoses Dementia, Hypertension and Thyroid Disease. The functional capacity screen (FCS) dated 12-29-14 recorded resident required physical assistance with bathing, dressing, toileting and management of medications/treatments; independent with transfers, walking/mobility and eating. Usually continent of bladder. Cognition: problems with short term memory, memory/recall and decision-making. Current problems identified included falls/unsteadiness, impaired vision, impaired hearing, impaired decision-making and socially disruptive inappropriate behavior. Resident uses walker and wheelchair. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 12-29-14 recorded: Independent with getting in/out of bed; limited assistance with dressing (assist with getting clothes out and cue resident to put them on - assist as needed). Required limited assistance with bathing twice a week (remind of shower day, adjust shower and cue to get into shower, provide stand by assistance). Resident is a high fall risk (requires observation from staff for safety needs). Make sure resident has on proper footwear and is using walker. Keep room free of clutter and obstacles. Report changes in gait, balance of level of consciousness. Addition to NSA on 1-3-15 stated, "Fall with self-transfer. Found on floor. Sent to emergency room. Returned with rib fractures. 1-6-15 x-ray left hip for complaint of pain. Left hip fracture. 1-7-15 sent to hospital." Independent with transfers.	S 135		

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Requires medication management. Certified medication aide to provide medication. Incontinence Care: resident requires cueing to go to the bathroom and provide self care after an incontinent episode.

Nurse's Notes:
1-4-15 at 10:20 am: "This writer was informed that this resident had an injury fall during the night and was sent to hospital via emergency medical services. Resident was present here at (facility) upon my arrival this morning. Resident's family member was notified at 10:05 am on 1-4-15, he/she was upset that he/she wasn't notified when incident occurred ..." Signed by licensed staff D. "After care instructions for rib fracture received." Signed by licensed staff D.

Incident Report stated the following:
1-3-15 at 11:45 pm: Where incident occurred - in resident's room. Resident stated that he/she fell and his/her right hip hurt. Staff Observation: "I found him/her during second rounds at 11:45 pm on the floor by his/her bedside, I have been in his/her room prior to this at 10:00 pm and offered my assist and he/she refused." Fall unwitnessed.

Interview on 2-19-15 at 6:07 pm with certified staff J confirmed he/she did not call the family on 1-3-15 regarding resident's fall and being sent to the hospital. Certified staff J stated he/she didn't call because it was late at night and, "I thought they might as well call in the morning."

For resident #4, the administrator failed to ensure that designated facility staff notified the resident's legal representative or designated family member upon occurrence on an accident involving the resident that resulted in injury and a decision to transfer the resident to the hospital.

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- Record review for resident #7 revealed admission on 1-3-15 with diagnoses Hypertension, Diabetes Mellitus, Congestive Heart Failure, Atrial Fibrillation, Dementia, and Depression.

The functional capacity screen (FCS) dated 12-31-14 recorded resident required physical assistance with bathing, dressing, toileting, transfers and management of medications/treatments; independent with walking/mobility and eating. Frequently incontinent of bladder. Cognition: problems with short term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness, impaired hearing and impaired decision-making.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 1-2-15 recorded the following services:
Morning/Night Care and Dressing: requires staff to assist out of bed and dressing. Able to bear weight. Explain what you are doing and have wheelchair ready.
Bathing: requires hands on assistance.
Fall Risk: High Fall Risk: Assist with all transfers. Assist taking resident to the bathroom. Make sure wearing proper footwear and keep room free of clutter/obstacles.
Incontinence Care: requires assistance with transferring on and off toilet and changing pull up when soiled.
Additions to NSA/HCSP:
1-15-15: found lying beside bed. stated she was getting up from wheelchair. resident to be kept in common area while awake. therapy notified.
1-16-15: found lying on floor beside bed. assisted

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S 135	Continued From page 8 into wheelchair for awhile and then back to bed due to resident being ill with flu. Continue on therapy. 1-18-15: found on knees beside bed. stated trying to get out of bed. assisted into wheelchair and taken to common area. toilet resident every morning at 7:00 am. Therapy notified. 2-18-15: slipped off bed to floor with no shoes on and paper chux. shoes put on resident and staff educated not to use paper chux. 2-12-15: rolled out of bed, bed is newer and smaller. bed placed in lowest position. Nurse's Notes: 1-16-15 at 10:00 pm: "Resident found screaming on floor. No apparent injury. Vital signs: blood pressure 126/72, Respirations 18, Pulse 68, oxygen saturation 98%." (entry lacked signature). The record lacked documentation of notification of physician. Interview on 2-23-15 at 1:57 pm with licensed staff C confirmed the record lacked documentation of notification of the resident's physician of the fall. For resident #7, the administrator failed to ensure that designated facility staff consulted with the resident's physician when the resident experienced an accident that had the potential for requiring a physician's intervention.	S 135		
S3155 SS=G	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 9 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 reported a census of 39 residents. The sample included 9 residents and 1 closed record review. Based on record review and interview for 1 (#3) of 9 sampled residents with impaired cognition and multiple falls, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident when the licensed nurse failed to provide or coordinate interventions to address this cognitively impaired residents increased risk for falls following a fall that resulted in a laceration to the back of the head that required staples. The resident fell again 2 days later, suffered another head injury resulting in a subdural hematoma. Findings included: - Record review for resident #3 revealed admission on 10-2-13 with diagnoses Dementia, Anxiety, Depression, Diabetes Mellitus, Hypertension and Hyperlipidemia. The functional capacity screen (FCS) dated 11-26-14 recorded resident required physical assistance with bathing, dressing, toileting, eating, and management of medications/treatments; independent with transfers, and walking/mobility. Occasionally incontinent of bladder. Cognition: problems with	S3155		

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short term memory, long term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness and impaired decision-making.

The negotiated service agreement dated 11-26-14 recorded the following services:
Morning/Night care: Staff to remind resident that it is bedtime and cue to put on nightgown and get into bed.
Dressing: assist with dressing daily.
Bathing: Staff to remind of shower day, adjust shower, cue to undress and step into shower.
Scheduled courtesy checks: Check on resident at night but do not wake. Resident wakes up at times at night and becomes confused and at times believes that he/she is getting kicked out or that something has happened to children. Reassure.
Dining: leaves the dining room frequently without eating. Cue to come back and eat.
Toileting: Continent of bladder and stool.
Fall risk: High Fall Risk. Keep room free of obstacles and clutter. Resident walks in hallways most of the time. Encourage resident to sit and rest. Assist resident with changing his/her pull up as needed.
Transfer ability: independent transfer to and from bed, chair, laying, sitting, standing. Can tolerate distances and sustained activity.
Incontinence Care: Resident has pull ups. Resident would rather wear underwear and does take the pull up off. Resident has occasional incontinence of urine and does require assistance with changing with incontinent episodes.

Additions to NSA:
2-3-15: Fall in bistro. Skin tear to left elbow. No shoes on. Loose stool on clothes and floor. Ensure resident has on shoes.

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2-13-15: Do not give resident ensure while he/she is walking. Have resident sit and drink it and sit with him/her. As you encourage resident to sit and rest, sit with him/her and talk calmly, have him/her hold a baby, a book or stuffed animal.

Nurse ' s Notes revealed the following:

2-3-15 at 2:40 pm: " Resident was found lying on the floor in bistro with no pants or shoes on. There was diarrhea on the floor and on resident ' s clothes. (Staff) were attempting to clean resident while he/she was trying to get up off the floor. Range of motion was completed without difficulty. Resident has no complaint of pain at this time. Skin tear was noted on left elbow ...unable to obtain vital signs at this time, resident agitated and will not be still ... " Signed by licensed staff D.

2-9-15 at 7:15 am: " Resident assistant noted resident coming out of room with blood running down face. Blood noted on threshold to bathroom. Nurse applied pressure to 1 centimeter cut mid forehead and applied steri-strips .... " Signed by licensed staff C.

Facility incident report dated 2-12-15 at 3:40 pm: " Resident laying on floor in hallway near kitchen. Resident was supine with head against door trim. Blood dripping from back of head. Ensure container and ensure on floor. Resident with straw in hand. " Signed by licensed staff C.

Hospital " After Care Instructions " dated 2-12-15 at 5:49 pm stated: symptoms can last from hours to months ... You might have a mild

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S3155	Continued From page 12 headache for a few days ... Seek immediate medical attention if any of the following occurs: headache gets worse/changes; neck pain, fever, vision changes, difficulty walking or change in behavior, you faint, vomit or cannot keep medication down. Instructions For: Head Injury: You have been seen for a head injury Instructions For: Scalp Laceration: You have been seen and treated for a laceration in your scalp. Your wound has been repaired with surgical staples ....4. Keep wound clean and dry for next 24 hours and avoid excessive moisture. Can wash gently with soap and water then keep area as clean and dry as possible. Unless instructed to do otherwise, you can place a thin layer of antibiotic ointment over the wound. Follow up with physician ...staple removal in 7-10-days. The record lacked documentation on the 2-12-15 fall, emergency room visit or presence of staples in scalp upon return from the emergency room. The record further lacked documentation of health care services to address assessment and monitoring of resident following head injury and laceration with surgical staples and documentation of health care services to address the resident ' s increased risk for falls. 2-14-15 at 9:35 am: " At around 9:15 am this nurse was called ...due to resident laying on the floor outside bathroom by the beauty shop. Resident was bleeding from his/her head and blood was also on the floor. Resident was asked what happened. He/She stated ' I want to get up ' . Resident unable to move head due to pain (grimacing in pain). Doctor was called and resident was sent to emergency room via 911 ambulance which was called immediately.	S3155		

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S3155	Continued From page 13 Resident was not moved until paramedics arrived ...resident was taken to hospital. Vitals: blood pressure 134/68, pulse 70, respirations 24. Oxygen saturation 93% on room air. " Signed by licensed staff E. Hospital report of CT (computed tomography xray) findings on 2-14-15: " Impression: . . . findings of a thin acute subdural hematoma ...critical results were called to physician in the emergency department 2-14-15 11:00 am. " Interview with administrative staff A on 2-23-15 at 3:07 pm stated resident died Friday (2-20-15). Stated resident went from here to the hospital and family reported he/she was admitted to the hospice house where he/she stopped eating and died. Interview on 2-18-15 at 5:35 pm with licensed staff C confirmed the resident was a high fall risk and the NSA/HCSP lacked documentation of a health care service plan specific to meet the resident ' s increased risk of falls. Confidential Interview with certified staff on 2-19-15 at 5:55 pm stated information about resident incidents and care was provided during walking rounds and during stand up meetings at 3:30 pm with the administrator and licensed staff C; further stated he/she did not receive any specific information after resident ' s falls. " We were mainly told to try to get him/her to sit down. He/she would literally walk until he/she fell asleep. " Confidential Interview with certified staff on 2-19-15 at 6:07 stated " We perform walking rounds with off going staff, get a verbal report and check the communication log. " Further stated "	S3155		

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S3155	Continued From page 14 if I can ' t get enough detail, I go check the 24 hour book. That will tell me what happened, but not what to do. " For resident #3, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident when the licensed nurse failed to provide or coordinate interventions to address this cognitively impaired residents increased risk for falls following a fall that resulted in a laceration to the back of the head that required staples. The resident fell again 2 days later, suffered another head injury resulting in a subdural hematoma.	S3155		
S3171 SS=E	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 39 residents. The sample included 9 residents and 1 closed record review. Based on record review and interview for 4 (#6, #7, #8, #9) of 9 sampled residents with falls, the administrator failed to ensure all health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #6 revealed	S3171		

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admission on 5-13-13 with diagnoses Anxiety, Back Pain, Dementia, Depression, Gait Disturbance, Gastoesophogeal Reflux Disease, Hypothyroidism, Insomnia, Myasthenia Gravis, and Parkinson ' s Disease.

The functional capacity screen dated 11-20-14 recorded resident required physical assistance with bathing, dressing, toileting and management of medications/treatments. Frequently incontinent of bladder. Cognition: problems with short term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness and impaired decision-making.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 11-20-14 recorded the following services:
Morning/Night Care: requires limited assistance getting out of bed and hands on assistance with night time preparation. Staff to assist resident with getting out of bed using cues and reminders. Assist out of bed, have wheelchair ready and assist to pivot to wheelchair.
Dressing: requires hands on assistance.
Bathing: requires hands on assistance with bathing.
Scheduled courtesy checks: requires to be checked on routine nightly rounds.
Fall Risk: High Fall Risk: make sure walker or wheelchair is within reach. When ambulating remind to walk up close to walker. At times resident is unable to ambulate well and requires use of wheelchair.
Additional notes: 1-16-15 resident ill and weak. Staff to check on frequently while ill.
2-12-15 physical and occupational therapy evaluation and treatment for slumping in chair and ability to eat.
Transfer ability: requires limited assistance with

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transfers. Cue resident and have walker or wheelchair ready.
Incontinence Care: Hand on assistance with toileting and incontinence care. Requires assistance getting onto the toilet and assistance changing pull up. Provide pericare. Wears a pull up with a pad in it.

Nurse ' s Notes:
1-17-15 (2-10) pm: " Very calm and looked sickly. Didn ' t come out to eat. Blood pressure 116/70, pulse 72. Respirations 20, oxygen saturation 96%. " Entry lacked signature. The record lacked documentation of notification and assessment by a licensed nurse.

Interview on 2-23-15 at 1:34 pm with licensed staff C confirmed resident was not assessed by a licensed nurse. Confirmed entry was made by certified staff J.

For resident #6, the administrator failed to ensure all health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice by ensuring notification and assessment by a licensed nurse when the resident experienced symptoms of illness.

- Record review for resident #7 revealed admission on 1-3-15 with diagnoses Hypertension, Diabetes Mellitus, Congestive Heart Failure, Atrial Fibrillation, Dementia, and Depression.

The functional capacity screen (FCS) dated 12-31-14 recorded resident required physical assistance with bathing, dressing, toileting, transfers and management of

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medications/treatments; independent with walking/mobility and eating. Frequently incontinent of bladder. Cognition: problems with short term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness, impaired hearing and impaired decision-making.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 1-2-15 recorded the following services:
Morning/Night Care and Dressing: requires staff to assist out of bed and dressing. Able to bear weight. Explain what you are doing and have wheelchair ready.
Bathing: requires hands on assistance.
Fall Risk: High Fall Risk: Assist with all transfers. Assist taking resident to the bathroom. Make sure wearing proper footwear and keep room free of clutter/obstacles.
Incontinence Care: requires assistance with transferring on and off toilet and changing pull up when soiled.
Additions to NSA/HCSP:
1-15-15: found lying beside bed. stated she was getting up from wheelchair. resident to be kept in common area while awake. therapy notified.
1-16-15: found lying on floor beside bed. assisted into wheelchair for awhile and then back to bed due to resident being ill with flu. Continue on therapy.

Nurse's Notes:
1-16-15 at 10:00 pm: "Resident found screaming on floor. No apparent injury. Vital signs: blood pressure 126/72, Respirations 18, Pulse 68, oxygen saturation 98%." (entry lacked signature). The record lacked documentation of notification and assessment by a licensed nurse at the time of the fall.

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S3171	Continued From page 18 Interview on 2-23-15 at 1:57 pm with licensed staff C confirmed the record lacked documentation of an assessment by a licensed nurse and signature of staff who made the entry. Confirmed entry was made by certified staff J. For resident #7, the administrator failed to ensure all health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice by ensuring notification and assessment by a licensed nurse at the time of the fall. - Record review for resident #8 revealed admission on 4-16-13 with diagnoses Dementia, Hypertension, Hypercholesterol, Major Depressive Disorder, and Transient Ischemic Attacks. The FCS dated 11-21-14 recorded resident required physical assistance with bathing, dressing, toileting and management of medications/treatments; supervision with transfers and walking/mobility; and independent with eating. The NSA dated 11-21-14 recorded the following services: Morning/Night Care: requires limited assistance getting out of bed and hands on assistance with night time preparation. Dressing: requires hands on assistance. Bathing: service provided by hospice aide. Dining: independent with dining. Fall Risk: High Fall Risk: when in room, check frequently, make sure has wheelchair nearby. When upset greater fall risk. 1-16-15: staff to check on resident and assist to bathroom as	S3171		

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needed.
Transfer ability: requires limited assistance with transfers. Cue and provide stand by assistance. Escort to meals and activities.
Incontinence care: requires hands on assistance with toileting and incontinence care.

Nurse ' s Notes:
1-16-15 (no time documented): " Resident found on floor at 9:45 pm. No apparent injury. Vital signs: blood pressure 122/72, pulse 70, respirations 18, temperature 97.6, oxygen saturation 97%." The entry lacked a signature. The record lacked documentation of notification and assessment by a licensed nurse at the time of the fall.

Interview on 2-23-15 at 2:22 pm with licensed staff C confirmed the record lacked documentation of notification of a licensed nurse and an assessment. Confirmed entry was made by certified staff J.

For resident #8, the administrator failed to ensure all health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice by ensuring notification and assessment by a licensed nurse at the time of the fall.

- Record review for resident #9 revealed admission on with diagnoses Dementia, Atrial Fibrillation, Diabetes Mellitus, Vitamin D Deficiency, and Depression.

The functional capacity screen dated 12-13-14 recorded resident required physical assistance with bathing, dressing, toileting and management of medications/treatments; and independent with

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S3171	Continued From page 20 transfers, walking/mobility and eating. The negotiated service agreement/health care service plan (NSA/HCSP) dated 12-13-14 recorded the following services: Morning/Night Care: requires hands on care with night time preparation. Dressing: requires hands on care with dressing tasks. Bathing: requires hands on assistance with bathing. Scheduled courtesy checks: requires routine nightly checks. If awake assist to the bathroom. Fall Risk: High Fall Risk: ensure walker always nearby and that resident uses it; ensure wearing proper footwear; assist with putting legs into center of bed and assist into center of bed; keep room free of clutter; encourage to sit and rest. Transfer ability: independent transfer to and from bed, chair, laying, sitting, standing. Incontinence Care: requires staff to change pull up when soiled and provide pericare, takes self to bathroom and does not get pants down far enough and soils the back of the pants. Additions to plan: 12-29-14 sitting on floor with back against bed. Assisted into bed with hips and legs repositioned. 1-1-15 fall outside room. Had been up all night and was tired. Assisted into bed. 1-11-15 complained of right arm pain yelling. Sent to emergency room. Resident using wheelchair due to pain with using walker. 1-12-15 found lying on floor next to bed. Scratch on back. Resident brought to common area. 1-26-15 physical and occupational therapy. 1-11-14 at 12:24 am: " Resident kept screaming help and said he/she has pain on his/her shoulder. He/She said he/she can ' t raise it and went on to further say he/she had pain in his/her	S3171		

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S3171	Continued From page 21 whole body. Vital signs: blood pressure 134/76, temperature 97.6, pulse 80, respirations 20, oxygen saturation 97%. The entry lacked a signature. The record lacked documentation of notification and assessment by a licensed nurse for the resident who experienced severe pain. Interview on 2-23-15 at 3:35 pm with licensed staff C confirmed the record lacked documentation of notification and assessment by a licensed nurse. Confirmed entry was made by certified staff J. For resident #9, the administrator failed to ensure all health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice by ensuring notification and assessment by a licensed nurse when the resident experienced symptoms of pain.	S3171		
S3261 SS=D	26-41-105 (f) (11) Resident Record 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 26-41-105(f)(11) The facility reported a census of 39 residents. The sample included 9 residents and 1 closed record review. Based on record review and interview for 1 (#3) of 9 sampled residents, the	S3261		

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S3261	Continued From page 22 administrator failed to ensure documentation of all incidents, and indications of injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #3 revealed admission on 10-2-13 with diagnoses Dementia, Anxiety, Depression, Diabetes Mellitus, Hypertension and Hyperlipidemia. The functional capacity screen (FCS) dated 11-26-14 recorded resident required physical assistance with bathing, dressing, toileting, eating, and management of medications/treatments; independent with transfers, and walking/mobility. Occasionally incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks: falls/unsteadiness and impaired decision-making. The negotiated service agreement dated 11-26-14 recorded the following services: Morning/Night care: Staff to remind resident that it is bedtime and cue to put on nightgown and get into bed. Dressing: assist with dressing daily. Bathing: Staff to remind of shower day, adjust shower, cue to undress and stop into shower. Scheduled courtesy checks: Check on resident at night but do not wake. Resident wakes up at times at night and becomes confused and at times believes that he/she is getting kicked out or that something has happened to children. Reassure. Dining: leaves the dining room frequently without eating. Cue to come back and eat.	S3261		

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Toileting: Continent of bladder and stool.
Fall risk: High Fall Risk. Keep room free of obstacles and clutter. Resident walks in hallways most of the time. Encourage resident to sit and rest. Assist resident with changing his/her pull up as needed.
Transfer ability: independent transfer to and from bed, chair, laying, sitting, standing. Can tolerate distances and sustained activity.
Incontinence Care: Resident has pull ups. Resident would rather wear underwear and does take the pull up off. Resident has occasional incontinence of urine and does require assistance with changing with incontinent episodes.
Additions to NSA:
2-3-15: Fall in bistro. Skin tear to left elbow. No shoes on. Loose stool on clothes and floor. Ensure resident has on shoes.
2-13-15: Do not give resident ensure while he/she is walking. Have resident sit and drink it and sit with him/her. As you encourage resident to sit and rest, sit with him/her and talk calmly, have him/her hold a baby, a book or stuffed animal.

The record lacked documentation of a fall on 2-12-15 at 3:40 pm.

Facility incident report dated 2-12-15 at 3:40 pm: " Resident laying on floor in hallway near kitchen. Resident was supine with head against door trim. Blood dripping from back of head. Ensure container and ensure on floor. Resident with straw in hand. " Signed by licensed staff C.

Hospital "After Care Instructions" dated 2-12-15 at 5:49 pm stated: symptoms can last from hours to months ...5. You might have a mild headache for a few days ...7. Seek immediate medical attention if any of the following occurs: headache gets worse/changes; neck pain, fever, vision

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changes, difficulty walking or change in behavior, you faint, vomit or cannot keep medication down. Instructions For: Head Injury: 1. You have been seen for a head injury ....3. Head injury Instructions For: Scalp Laceration: 1.You have been seen and treated for a laceration in your scalp. 2. Your wound has been repaired with surgical staples ....4. Keep wound clean and dry for next 24 hours and avoid excessive moisture. Can wash gently with soap and water then keep area as clean and dry as possible. 5. Unless instructed to do otherwise, you can place a thin layer of antibiotic ointment over the wound. Follow up with physician ...staple removal in 7-10-days."

The record lacked documentation of resident going to the hospital and returning with staples to scalp. Further lacked documentation of an ongoing assessment performed by a nurse for monitoring after a head injury and assessment of the scalp laceration.

Interview on 2-18-15 at 5:35 pm with licensed staff C confirmed the record lacked documentation of the fall on 2-12-15, trip to the emergency room, return to the facility and follow up observation.

For resident #3, the administrator failed to ensure documentation of all incidents, and indications of injury including date, time of occurrence, action taken and results of the action when the resident experienced a fall, went to the hospital and returned with a stapled head laceration.