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	N087071	A. BUILDING: _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #92700, #92775, #93489, #92888, #97719, and #100591 of the above residential health care facility on 7/11/16, 7/12/16, 7/13/16, and 7/14/16.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S3028		

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

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S3028	Continued From page 1 by: KAR 26-41-101(f)(3)(A) The facility reported a census of 35 residents. The sample included 3 residents and 3 closed records focus review. Based on record review, interview, and observation for 3 (#526, #527, and #525) the administrator failed to report to the department within 24 hours of incidents involving a cognitively impaired resident in order to rule out abuse and/or neglect. Findings included: - Record review for resident #526 revealed an admission date of 11/8/14 and a diagnosis of Alzheimer's dementia. The functional capacity screen dated 3/16/16 indicated the resident was at risk for falls, experienced impaired short-term and long-term memory, decision making, and memory recall; was independent with mobility; required supervision with transferring; required physical assistance with toileting; and was frequently incontinent of urine. The functional capacity screen documented the resident did not utilize an assistive device with mobility. The record lacked a functional capacity prior to the screen dated 3/16/16. The negotiated service agreement/health care service plans dated 1/12/16 and 4/13/16 each documented resident was "a limited fall risk at this time due to unsteady gait and weakness. Provide assistance if needed with ambulation." During tour of the facility at 10:30 a.m. on 7/11/16, observed resident #526 sitting in a wheelchair at a table in the front dining room. Observed an	S3028		

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alarm on the back of the wheelchair attached to resident's clothing. Observed bruising to right side of resident's face and a laceration with sutures above right eyebrow.

Review of the nurse's notes and facility fall investigations revealed the documentation by licensed nurses of reportable incidents involving the cognitively impaired resident as follows:

9/16/15 at 7:00 p.m. resident found on floor in hallway yelling help. Small laceration and small hematoma to back of head. Resident complained of pain, 911 notified and transported to hospital emergency department for evaluation. Intervention as a result of an investigation documented as "Make sure to watch stability when walking."

9/24/15 at 6:30 p.m. resident fell in front of wellness station and received a 4 centimeter laceration above right eye. Resident complained of right shoulder pain and sent to hospital emergency department for evaluation. Nurse's notes contained an entry that resident returned to the facility at 9:00 p.m. with fractured scapula. Intervention as a result of the investigation to make sure to assist resident when ambulating.

12/5/15 at 1:00 a.m. that resident yelling at 12:05 a.m. and found on floor with a laceration and 3 centimeter by 3 centimeter hematoma to back of head. Nurse notified 911 and sent resident to hospital emergency department. Intervention as a result of an investigation for resident to wear shoes or non-skid socks and encouraged to use walker for stability when walking.

1/1/16 at 3:20 a.m. that resident came out of resident's room with bleeding to back of head and

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bridge of nose with swelling above left eyebrow. Resident stated someone came into room and did this to resident and then stated he/she fell and hit head on a dresser. Found blood on floor beside bed and nightstand. Notified 911 and sent resident to hospital emergency department for evaluation. Administrator did not provide an investigation of this incident.

1/5/16 at 10:50 a.m. resident found on knees in the living room area. No injury noted. Administrator did not provide an investigation of this incident.

1/31/16 at 10:13 p.m. resident crawling on fall mat with no visible injuries. Administrator did not provide an investigation of this incident.

2/13/16 at 9:45 p.m. resident found on floor in the room of another resident with scratch marks to face and neck. Resident was stating "(He/She) hit me." Resident had previously been banging on doors screaming "open up." Investigation of the incident documented that resident had abrasions to right forehead, right cheek, and left neck. Intervention of prevent resident from opening and banging on doors.

5/21/16 for 3:00 p.m. to 11:00 p.m. shift that resident fell in hallway at 9:45 p.m. and complained of hip pain. Called 911 and sent resident to hospital emergency department for evaluation. At 1:37 a.m. on 5/22/16 resident returned to facility with diagnosis of fractured pelvis. Investigation documented intervention of staff will supervise safety of resident when ambulating.

6/29/16 at 3:30 a.m. resident found on floor at foot of bed around 1:45 a.m. Resident with

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laceration above right eyebrow. Sent to emergency department for evaluation. Resident required sutures of the laceration and returned to facility at 6:45 a.m. Investigation of the incident documented interventions of alarm in place at all times in bed or in chair, wheelchair placed in bathroom when resident in bed, prop door open when resident is in bed to be able to hear if resident gets up.

At 2:21 p.m. on 7/14/16, administrator stated the incident on 9/24/15 and the incident on 5/21/16 were each reported to the department and investigations submitted. Administrator stated there were no records that the other incidents were reported to the department.

The administrator failed to report to the department within 24 hours of incidents involving cognitively impaired resident #526 in order to rule out abuse and/or neglect.

- Record review for resident #527 revealed an admission date 3/25/13 and diagnosis of dementia.

The functional capacity screen dated 10/14/14 indicated resident was at risk for falls; independent with mobility with a walker; required supervision with toileting and transferring; was frequently incontinent of urine; and experienced impaired short-term and long-term memory, decision making, and memory recall.

The negotiated service agreement/health care service plan dated 10/26/15 documented the service of extensive hands-on assistance with ambulation and one-person transfer assistance. Ensure personal alarm is on when in wheelchair. The negotiated service agreement/health care

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service plans dated 4/29/16 and 1/19/16 each documented services of hands-on assistance with transfers and ambulation, ensure pathway is clear, apartment free of clutter, and resident has appropriate mobility aids.

At 11:50 a.m. on 7/11/16, observed resident sitting in a wheelchair at a table in the front dining room and noted bruising on the left side of the resident's face from beside left eye down to chin. Observed a personal alarm attached to the wheelchair and to the resident's clothing.

Review of the nurse's notes and facility fall investigations revealed the documentation by licensed nurses of reportable incidents involving the cognitively impaired resident as follows:

9/2/15 at 3:38 a.m. heard resident yelling at 2:45 a.m. and found resident on floor next to bed with a 4 centimeter laceration and hematoma to left side of the head. Called 911 and resident transported to hospital emergency department for evaluation. Documentation at 9:05 p.m. on 9/2/15 that resident admitted to surgical intensive care for monitoring. Nurse's notes contained documentation that resident returned to facility on 9/5/15. The record contained a medical care provider note dated 9/8/15 that resident did develop a subdural hematoma due to the fall on 9/2/15. Investigation of the incident documented intervention of bed alarm to be put in place to supplement body alarm.

10/5/15 at 12:00 a.m. documentation that around 11:30 p.m. resident trying to stand from chair and lost balance a certified employee assisted resident to floor and resident hit head on floor causing a 2 centimeter by 3 centimeter hematoma. Investigation of the incident

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S3028	Continued From page 6 documented resident had removed personal alarm and interventions of place alarm attachment where resident cannot reach and visual checks for proper placement of alarm. 2/26/16 at 11:55 p.m. that resident at 11:15 p.m. fell in television room when trying to walk with a walker. Resident experienced a hematoma to left side of head with bleeding. Resident sent to hospital emergency department for evaluation and returned to the facility at 3:00 a.m. on 2/27/16. Investigation of the incident documented interventions of do not leave resident unattended in living room and personal alarm on at all times. 6/25/16 at 3:45 a.m. resident found on floor at 2:30 a.m. with hematoma to right side of face proximal to right eye. Resident stated he/she slid while trying to get to bathroom. Resident to hospital emergency department for evaluation. Investigation of the incident documented resident received a 6 centimeter hematoma. Resident stated was trying to go to bathroom and lights were off. Interventions of ensure night lights are on and bed alarm in place. 7/7/16 (unable to read time) staff getting ready to transfer resident from recliner to wheelchair and resident was quick to get up and slid to floor receiving s 2 centimeter by 2 centimeter hematoma to left side of face. Administrator did not provide an investigation of this incident. At 2:21 p.m. on 7/14/16, administrator stated he/she did not have records that these incidents were reported to the department. The administrator failed to report to the department within 24 hours of incidents involving cognitively impaired resident #527 in order to rule out abuse and/or neglect.	S3028		

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- Record review for resident #525 revealed an admission date of 2/6/16 and diagnoses of dementia and Parkinson's disease.

The functional capacity screen dated 2/6/16 indicated the resident was at risk for falls; required physical assistance with transferring, toileting, and mobility with walker or wheelchair; and was usually continent of bladder. The functional capacity screen lacked a score to indicate resident's cognition.

The negotiated service agreement/health care service plan dated 6/2/16 documented resident ambulates in wheelchair with staff assistance, one-person transfer, increase resident's time out of his/her room, and use of personal alarm. Review of the nurse's notes and facility fall investigations revealed the documentation by licensed nurses of reportable incidents involving the cognitively impaired resident as follows:

2/29/16 at 11:00 p.m. resident found on floor face down with cut on top of right eyebrow around 10:00 p.m. Called 911 and resident transported to hospital for evaluation. Investigation of incident documented resident had been sleeping on couch in television room and rolled off of couch. Intervention of do not leave unattended in television room.

3/14/16 at 9:30 a.m. resident fell when walking out of dining room. Investigation documented interventions of use of personal alarm and one-person assistance with ambulation.

3/18/16 at 8:30 p.m. Resident held on to another resident trying to get up from sitting position and

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S3028	Continued From page 8 fell. Investigation documented same as cause of fall. 6/11/16 at 2:07 p.m. resident found on floor in room and resident unable to explain what happened. Complained of hip pain and x-rays ordered. Investigation documented resident stated he/she fell. Spouse also present but unable to state what happened. At 2:21 p.m. on 7/14/16, administrator stated he/she did not have records that these incidents were reported to the department. The administrator failed to report to the department within 24 hours of incidents involving cognitively impaired resident #525 in order to rule out abuse and/or neglect.	S3028		
S3155 SS=E	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 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 35 residents. The sample included 3 residents and 3 closed records focus review. Based on record review, observation, and interview for 2 (#526 and #527)	S3155		

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of 3 residents sampled, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident.

Findings included:

- Record review for resident #526 revealed an admission date of 11/8/14 and a diagnosis of Alzheimer's dementia.

The functional capacity screen dated 3/16/16 indicated the resident was at risk for falls, experienced impaired short-term and long-term memory, decision making, and memory recall; was independent with mobility; required supervision with transferring; required physical assistance with toileting; and was frequently incontinent of urine. The functional capacity screen documented the resident did not utilize an assistive device with mobility. The record lacked a functional capacity prior to the screen dated 3/16/16.

The negotiated service agreement/health care service plans dated 1/12/16 and 4/13/16 each documented resident was "a limited fall risk at this time due to unsteady gait and weakness. Provide assistance if needed with ambulation."

During tour of the facility at 10:30 a.m. on 7/11/16, observed resident #526 sitting in a wheelchair at a table in the front dining room. Observed an alarm on the back of the wheelchair attached to resident's clothing. Observed bruising to right side of resident's face and a laceration with sutures above right eyebrow.

Review of the nurse's notes and facility fall investigations revealed the following

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documentation by licensed nurses:

9/16/15 at 7:00 p.m. resident found on floor in hallway yelling help. Small laceration and small hematoma to back of head. Resident complained of pain, 911 notified and transported to hospital emergency department for evaluation. Intervention as a result of an investigation documented as "Make sure to watch stability when walking."

9/24/15 at 6:30 p.m. resident fell in front of wellness station and received a 4 centimeter laceration above right eye. Resident complained of right shoulder pain and sent to hospital emergency department for evaluation. Nurse's notes contained an entry that resident returned to the facility at 9:00 p.m. with fractured scapula. Intervention as a result of the investigation to make sure to assist resident when ambulating.

9/28/15 at 11:00 a.m. documentation that resident experienced a fall from a chair on the patio on 9/24/15 at 3:55 p.m. and no injury noted. Intervention as a result of an investigation to watch stability when walking.

10/2/15 at 8:05 a.m. resident in common area standing next to wheelchair. Brakes were not locked on wheelchair and resident fell to floor. No injury noted. Intervention as a result of an investigation resident to have stand-by assistance with ambulation.

12/5/15 at 1:00 a.m. that resident yelling at 12:05 a.m. and found on floor with a laceration and 3 centimeter by 3 centimeter hematoma to back of head. Nurse notified 911 and sent resident to hospital emergency department. Intervention as a result of an investigation for resident to wear

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shoes or non-skid socks and encouraged to use walker for stability when walking.

1/1/16 at 3:20 a.m. that resident came out of resident's room with bleeding to back of head and bridge of nose with swelling above left eyebrow. Resident stated someone came into room and did this to resident and then stated he/she fell and hit head on a dresser. Found blood on floor beside bed and nightstand. Notified 911 and sent resident to hospital emergency department for evaluation. Administrator did not provide an investigation of this incident.

1/5/16 at 10:50 a.m. resident found on knees in the living room area. No injury noted. Administrator did not provide an investigation of this incident.

1/11/16 at 2:51 a.m. resident fell when leaning on another resident. Small bump to left side of head. Investigation documented "monitor resident."

1/31/16 at 10:13 p.m. resident crawling on fall mat with no visible injuries. Administrator did not provide an investigation of this incident.

2/13/16 at 9:45 p.m. resident found on floor in the room of another resident with scratch marks to face and neck. Resident was stating "(He/She) hit me." Resident had previously been banging on doors screaming "open up." Investigation of the incident documented that resident had abrasions to right forehead, right cheek, and left neck. Intervention of prevent resident from opening and banging on doors.

5/21/16 for 3:00 p.m. to 11:00 p.m. shift that resident fell in hallway at 9:45 p.m. and

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complained of hip pain. Called 911 and sent resident to hospital emergency department for evaluation. At 1:37 a.m. on 5/22/16 resident returned to facility with diagnosis of fractured pelvis. Investigation documented intervention of staff will supervise safety of resident when ambulating.

6/29/16 at 3:30 a.m. resident found on floor at foot of bed around 1:45 a.m. Resident with laceration above right eyebrow. Sent to emergency department for evaluation. Resident required sutures of the laceration and returned to facility at 6:45 a.m. Investigation of the incident documented interventions of alarm in place at all times in bed or in chair, wheelchair placed in bathroom when resident in bed, prop door open when resident is in bed to be able to hear if resident gets up.

At 10:40 a.m. on 7/12/16, observed certified staff B and certified staff C in resident's room with resident. Certified staff B assisted resident to transfer from wheelchair to toilet and stated resident used wheelchair for mobility and physical therapy working with resident to walk with walker. Certified staff B stated fall interventions of keep resident in sight and personal alarm on resident. Certified staff C stated at night when resident is in bed keep personal alarm on, door propped open in order to hear if resident getting out of bed and fall mats beside bed. Observed a fall mat on floor on each side of bed.

At 3:55 p.m. on 7/12/16, licensed nurse A stated falls were investigated and interventions documented but these interventions were not added to resident's negotiated service agreement/health care service plan.

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S3155	Continued From page 13 The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #526. - Record review for resident #527 revealed an admission date 3/25/13 and diagnosis of dementia. The functional capacity screen dated 10/14/14 indicated resident was at risk for falls; independent with mobility with a walker; required supervision with toileting and transferring; was frequently incontinent of urine; and experienced impaired short-term and long-term memory, decision making, and memory recall. The negotiated service agreement/health care service plan dated 10/26/15 documented the service of extensive hands-on assistance with ambulation and one-person transfer assistance. Ensure personal alarm is on when in wheelchair. The negotiated service agreement/health care service plans dated 4/29/16 and 1/19/16 each documented services of hands-on assistance with transfers and ambulation, ensure pathway is clear, apartment free of clutter, and resident has appropriate mobility aids. At 11:50 a.m. on 7/11/16, observed resident sitting in a wheelchair at a table in the front dining room and noted bruising on the left side of the resident's face from beside left eye down to chin. Observed a personal alarm attached to the wheelchair and to the resident's clothing. Review of the nurse's notes and facility fall investigations revealed the following documentation by licensed nurses:	S3155		

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	N087071	A. BUILDING: _____ B. WING _____	07/14/2016

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S3155	Continued From page 14 9/2/15 at 3:38 a.m. heard resident yelling at 2:45 a.m. and found resident on floor next to bed with a 4 centimeter laceration and hematoma to left side of the head. Called 911 and resident transported to hospital emergency department for evaluation. Documentation at 9:05 p.m. on 9/2/15 that resident admitted to surgical intensive care for monitoring. Nurse's notes contained documentation that resident returned to facility on 9/5/15. The record contained a medical care provider note dated 9/8/15 that resident did develop a subdural hematoma due to the fall on 9/2/15. Investigation of the incident documented intervention of bed alarm to be put in place to supplement body alarm. 10/5/15 at 12:00 a.m. documentation that around 11:30 p.m. resident trying to stand from chair and lost balance a certified employee assisted resident to floor and resident hit head on floor causing a 2 centimeter by 3 centimeter hematoma. Investigation of the incident documented resident had removed personal alarm and interventions of place alarm attachment where resident cannot reach and visual checks for proper placement of alarm. 2/26/16 at 11:55 p.m. that resident at 11:15 p.m. fell in television room when trying to walk with a walker. Resident experienced a hematoma to left side of head with bleeding. Resident sent to hospital emergency department for evaluation and returned to the facility at 3:00 a.m. on 2/27/16. Investigation of the incident documented interventions of do not leave resident unattended in living room and personal alarm on at all times. 6/25/16 at 3:45 a.m. resident found on floor at 2:30 a.m. with hematoma to right side of face proximal to right eye. Resident stated he/she slid	S3155		

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S3155	Continued From page 15 while trying to get to bathroom. Resident to hospital emergency department for evaluation. Investigation of the incident documented resident received a 6 centimeter hematoma. Resident stated was trying to go to bathroom and lights were off. Interventions of ensure night lights are on and bed alarm in place. 7/7/16 (unable to read time) staff getting ready to transfer resident from recliner to wheelchair and resident was quick to get up and slid to floor receiving s 2 centimeter by 2 centimeter hematoma to left side of face. Administrator did not provide an investigation of this incident. During an interview at 3:40 p.m. on 7/12/16 licensed nurse A stated resident falls were investigated and interventions of lights on in room, fall mat beside bed, and personal alarm put in place but not documented in the negotiated service agreement/health care service plan. At 10:50 a.m. on 7/13/16 certified staff B listed fall interventions of keep resident in sight, be able to hear personal alarm sounding and fall mats beside bed. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #527.	S3155		
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	S3261		

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S3261	Continued From page 16 results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 35 residents. The sample included 3 residents and 3 closed records review. Based on record review, interview, and observation for 1 (#527) of 3 residents sampled, the licensed nurse failed to ensure the resident's record contained documentation of wound assessments in order to determine the results of wound treatment. Findings included: - Record review for resident #527 revealed an admission date 3/25/13 and diagnosis of dementia. Review of the resident roster revealed the resident had impaired skin integrity. Licensed nurse A stated resident currently had an open area on buttocks that a home health nurse was treating. The functional capacity screen dated 10/14/14 indicated resident was independent with mobility with a walker; required supervision with toileting and transferring; was frequently incontinent of urine; experienced impaired short-term and long-term memory, decision making, and memory recall; and was at risk for falls. The negotiated service agreement/health care service plan dated 4/29/16 documented services	S3261		

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S3261	Continued From page 17	S3261		

of physical assistance with mobility and transferring; bathing assistance; toileting assistance and incontinence care; and to monitor for changes in skin condition.

Review of the nurse's notes revealed the following entries regarding the presence of a wound:

5/14/16 at 6:50 a.m. noted small opening on buttock. Cream applied. Advised staff to toilet frequently and have sit in chair when not moving. This entry lacked an assessment that included the size of the wound, depth of wound, presence or absence of drainage, and description of surrounding skin.

6/13/16 for the 3:00 p.m. to 11:00 p.m. shift of resident ' s stage II ulcer reassessed. Wound healing well. Calmoseptine appears to be effective. This entry lacked an assessment that included the size of the wound, depth of wound, presence or absence of drainage, and description of surrounding skin.

7/1/16 at 4:30 p.m. Resident has new order to apply barrier cream three times a day. Diagnosis stage II excoriation on buttocks. Duoderm currently applied. This entry lacked an assessment that included the size of the wound, depth of wound, presence or absence of drainage, and description of surrounding skin.

7/6/16 at 11:50 a.m. requested order for home health to evaluate and treat if indicated.

7/12/16 at 5:00 p.m. New order received to discontinue Duoderm. This entry lacked an assessment that included the size of the wound, depth of wound, presence or absence of

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S3261	Continued From page 18 drainage, and description of surrounding skin. The record lacked documentation by a home health nurse of wound treatment and wound assessment. During an interview at 3:40 p.m. on 7/12/16, licensed nurse A provided documentation of a medical care provider's order dated 7/6/16 for home health to evaluate and treat if indicated for wounds. Licensed nurse A confirmed the resident's record lacked documentation of wound assessments by facility nurses and by the home health nurse. The licensed nurse failed to ensure the record for resident #527 contained documentation of wound assessments in order to determine the results of wound treatment.	S3261		