STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089040	A. BUILDING: _____ B. WING _____	03/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE BRIDGE OF TOPEKA	5800 SW DRURY LANE TOPEKA, KS 66604

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S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Residential Health Care Facility in Topeka, Kansas on 3/18/15, 3/19/15, and 3/23/15. Complaint #2217 also reviewed.	S 000		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The census equalled 37. The sample included two current Residents and one discharged Resident. Based on reviews of records and interviews, for two of three sampled (#187 and #189) the Operator failed to ensure the development of an initial negotiated service agreement (NSA) at admission. Findings included: - Review of record revealed #189 admitted to facility 02/06/15 with diagnoses of Parkinson's, Osteoarthritis, hyperlipidemia, Depression, Anxiety, Chronic vertigo, Dementia, Right Humerus fracture, Diabetes, Lewey body dementia, Dysphagia, General weakness, and Weight loss. The 02/06/15 functional capacity screen (FCS) assessed #189 in need of physical assistance (2)	S3090		

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

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with bathing, dressing, toileting, transfers, mobility, and eating; unable to perform (3) medication and treatment management, incontinent, with memory and cognitive impairments; with impaired decision making, falls, unsteadiness, required a brace, and used a wheelchair.
The admission NSA contained signature of the Operator 02/09/15 and signatures of the Licensed nurse and #189's family member on 02/10/15.

- Review of record revealed #187 admitted to facility 02/24/15 with diagnoses of Dementia, Irritable bowel syndrome, Anxiety, Hypertension, Aortic stenosis, and Transient ischemic attack.
The 02/24/15 FCS assessed #187 in need of physical assistance (2) with bathing; in need of supervision (1) dressing, toileting, and eating; unable to perform (3) medication and treatment management; with memory and cognitive impairment, wandering, and used a walker.
The admission NSA contained the signature of the Operator 02/26/15, and a note "mailed to DPOA (durable power of attorney) 2/26/15." This NSA completed two days after admission, lacked the signatures of the Resident/family member, or the licensed nurse.

On 3/19/15 at 1:54pm, Executive Director (ED) #H and Health and Wellness Director (HWD) #G stated we each complete a part of the NSA on the computer... #G completes the assessment... then locks the assessment... would of been done when he/she came in 02/06/15... then the system emails the ED... ED has to put in the financial part... was still in the system from 02/06/15 on, just not printed and signed...

The Operator failed to ensure the development of an initial NSA at admission for #187 and #189.

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S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The census equalled 37. The sample included two current Residents and one discharged Resident. The facility identified all Residents as receiving health care services. Based on reviews of records and interviews, for three of three sampled (#187, #185, and #189) the Operator failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan (HSP). Findings included: - Review of record revealed #189 admitted to facility 02/06/15 with diagnoses of Parkinson's, Osteoarthritis, hyperlipidemia, Depression, Anxiety, Chronic vertigo, Dementia, Right Humerus fracture, Diabetes, Lewey body dementia, Dysphagia, General weakness, and Weight loss. The 02/06/15 and 3/03/15 functional capacity screens (FCS) assessed #189 in need of physical assistance (2) with bathing, dressing, toileting, transfers, mobility, and eating; unable to perform (3) medication and treatment management, incontinent, with memory and cognitive impairments; with impaired decision making, falls,	S3165		

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S3165	Continued From page 3	S3165		

unsteadiness, required a brace, and used a wheelchair.
The 02/06/15 and 3/03/15 NSA's documented the needed health care services to be provided by facility.
The NSA's lacked the name of the licensed nurse responsible for the implementation and supervision of the plan.

- Review of record revealed #187 admitted to facility 02/24/15 with diagnoses of Dementia, Irritable bowel syndrome, Anxiety, Hypertension, Aortic stenosis, and Transient ischemic attack.
The 02/24/15 FCS assessed #187 in need of physical assistance (2) with bathing; in need of supervision (1) dressing, toileting, and eating; unable to perform (3) medication and treatment management; with memory and cognitive impairment, wandering, and used a walker.
The 3/18/15 FCS assessed #187 in need of physical assistance (2) with bathing and dressing; in need of supervision (1) with toileting and eating; unable to perform (3) medication and treatment management; with memory and cognitive impairment, falls/unsteadiness, wandering, and used a walker.
The 02/24/15 and 3/18/15 NSA's documented the needed health care services to be provided by facility.
The NSA's lacked the name of the licensed nurse responsible for the implementation and supervision of the plan.

- Review of record revealed #185 admitted to facility 02/01/13 with diagnoses of Dementia, Hyperlipidemia, Hypothyroidism, Depression, Anxiety, Personality disorder, Psychosis, Sundowning, Seasonal allergies, Upper respiratory infection, and Hypertension.
The 7/16/14 FCS assessed #185 in need of

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S3165	Continued From page 4 physical assistance (2) with bathing, dressing, toileting; unable to perform (3) medication and treatment management; with memory and cognitive impairment, falls/unsteadiness, and wandering. The 7/16/14 NSA documented the needed health care services to be provided by facility. The NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the plan. By interview on 3/19/15 at 1:54pm, Executive Director #H and Health and Wellness Director #G confirmed the NSA/HSP's lacked the name of the licensed nurse responsible for the overall plan... stated we have never been asked about that in the past... probably assumed the signature of a nurse on the back page covered that... The Operator failed to ensure the NSA's for #189, #185, and #187 contained the name of the licensed nurse responsible for the implementation and supervision of the HSP.	S3165		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for	S3200		

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S3200	Continued From page 5 which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The census equalled 37. The sample included two current Residents and one discharged Resident. The facility identified all Residents as receiving medication management. Based on reviews of records and interviews, for one of three sampled (#189) the Operator failed to ensure all medications administered to Residents in accordance with a medical care provider's written order and in accordance with professional standards of practice. Findings included: - Review of record revealed #189 admitted to facility 02/06/15 with diagnoses of Parkinson's, Osteoarthritis, hyperlipidemia, Depression, Anxiety, Chronic vertigo, Dementia, Right Humerus fracture, Diabetes, Lewey body dementia, Dysphagia, General weakness, and Weight loss. The current 3/03/15 functional capacity screen (FCS) assessed #189 unable to perform medication and treatment management. The current 3/03/15 negotiated service agreement (NSA) documented #189 to receive medication and treatment management by facility staff.	S3200		

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S3200	Continued From page 6 Review of the medical record revealed : 3/08/15 physician's order: "Maxitrol two drops in left eye every four hours for four days" 3/03/15 physician's order: "Norco 7.5/325 1/2 tab BID (twice daily) at 1200 and 1600; Continue 7.5 BID; every four hour PRN (as needed) to continue." 3/10/15 APRN's (advanced practice registered nurse) order: "Decrease Lortab 7.5mg (milligrams)/325 to 1/2 tab every 8AM." Review of the current March 2015 MAR (medication administration record) revealed: Maxitrol initiated on 3/10/15 at 4:00pm, and scheduled four times daily at 0600, 1200, 1600, and 2000, instead of the ordered "every four hours" or six times per day. The Maxitrol documented as administered at 1600 and 2000 for five days, at 1200 one day, and 0600 three days. The MAR failed to document the Maxitrol administered in accordance with the written order and in accordance with professional standards of practice. Review of the current March 2015 MAR revealed: Norco 7.5mg/325 1/2 tab po (by mouth) TID (three times daily) at 8am, 12pm, 4pm; and Norco 7.5/325mg one po daily at 8pm. The MAR failed to document the Norco administered in accordance with the written order and in accordance with professional standards of practice. By interview on 3/19/15 at 10:45am, Health and Wellness Director #G confirmed the Maxitrol not scheduled or administered as ordered in	S3200		

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S3200	Continued From page 7 accordance with professional standards of practice. #G stated in regard to the Norco, #189 was getting a whole tablet at 8am and 8pm and 1/2 tab at 12pm and 4pm... we asked the APRN to decrease the morning dose due to drowsiness, so I just put it together on the MAR. The Operator failed to ensure all medications administered to #189 in accordance with a medical care provider's written order and in accordance with professional standards of practice.	S3200		
S3261 SS=F	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 census equalled 37. The sample included two current Residents and one discharged Resident. Based on reviews of records and interviews, for three of three sampled (#187, #185, and #189), the Operator failed to ensure each Resident's medical record contained the documentation of all incidents, symptoms, other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions.	S3261		

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S3261	Continued From page 8 Findings included: - Review of record revealed #189 admitted to facility 02/06/15 with diagnoses of Parkinson's, Osteoarthritis, hyperlipidemia, Depression, Anxiety, Chronic vertigo, Dementia, Right Humerus fracture, Diabetes, Lewey body dementia, Dysphagia, General weakness, and Weight loss. The 02/06/15 and 3/03/15 functional capacity screens (FCS) assessed #189 in need of physical assistance with bathing, dressing, toileting, transfers, mobility, and eating; unable to perform medication and treatment management, incontinent, with memory and cognitive impairments; with impaired decision making, falls, unsteadiness, required a brace, and used a wheelchair. The 02/06/15 and 3/03/15 NSA's documented the needed health care services to be provided by facility. Resident Log (RL) notes of the medical record documented: 02/06/15 - 8:00pm - Resident fell out of wheel chair EMS (emergency medical services) called... family notified, vitals taken... Resident sent to ER (emergency room) via EMS... 02/07/15 - 1220am - Resident arrived back to facility by A & A Transport. Received order for hydrocodone-acetaminophen... script faxed to pharmacy... The medical record documentation lacked: Location of incident, Circumstances of incident, Whether staff involved or witness to incident A licensed nurse assessment (physical status, injury location and description, orientation level,	S3261		

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etc) of #189 completed at the time of the incident, Treatment or first aid rendered and Resident's response,
Residents status and condition at time of transport to the ER.
Documentation of a licensed nurse assessment (physical status, injury location and description, orientation level, etc) of #189 completed at the time of return to the facility, and,
Any followup monitoring or assessment of #189's condition in the hours or days following the incident/injury (next entry of RL dated 02/09/15 described a visit by physician).

On 3/19/15 at 10:55am, Health and Wellness Director #G confirmed the medical record lacked any additional information... stated no other notes or assessments before or after the ER visit available.

The Operator failed to ensure #189's medical record contained the documentation of all incidents, symptoms, other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions.

- Review of record revealed #187 admitted to facility 02/24/15 with diagnoses of Dementia, Irritable bowel syndrome, Anxiety, Hypertension, Aortic stenosis, and Transient ischemic attack.
The 02/24/15 FCS assessed #187 in need of physical assistance (2) with bathing; in need of supervision (1) dressing, toileting, and eating; unable to perform (3) medication and treatment management; with memory and cognitive impairment, wandering, and used a walker.
The 3/18/15 FCS assessed #187 in need of physical assistance with bathing and dressing; in need of supervision with toileting and eating;

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unable to perform medication and treatment management; with memory and cognitive impairment, falls/unsteadiness, wandering, and used a walker.
The 3/18/15 NSA documented the needed health care services to be provided by facility.

Resident Log (RL) notes of the medical record documented:

3/11/15 - 1115 - Staff answered door alarm to patio. Resident on the ground with his/her walker. Walker was next to him/her. Resident denied any pain. Resident assisted up by two. Resident unable to state what happened. Resident assisted to room and to bed. Vitals obtained, family and physician notified.
3/11/15 - 11:15 - patio is dark after sunset.

The medical record documentation lacked:
Circumstances of the incident,
A licensed nurse assessment (physical status, injury location and description, orientation level, etc) of #187 completed at the time of the incident,
Treatment or first aid rendered and Resident's response, and,
Any followup monitoring or assessment of #187's condition in the hours or days following the incident/injury (next entry of RL dated 3/12/15 described a visit by APRN (advance practice registered nurse).

On 3/19/15 at 11:00am, Health and Wellness Director #G confirmed the medical record lacked any additional information... stated no other notes or assessments before or after the ER visit available.

The Operator failed to ensure #187's medical record contained the documentation of all

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incidents, symptoms, other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions.

- Review of record revealed #185 admitted to facility 02/01/13 with diagnoses of Dementia, Hyperlipidemia, Hypothyroidism, Depression, Anxiety, Personality disorder, Psychosis, Sundowning, Seasonal allergies, Upper respiratory infection, and Hypertension.
The 7/16/14 FCS assessed #185 in need of physical assistance with bathing, dressing, toileting; unable to perform medication and treatment management; with memory and cognitive impairment, falls/unsteadiness, and wandering.
The 7/16/14 NSA documented the needed health care services to be provided by facility.

Resident Log (RL) notes of the medical record documented:

12/15/14 - 10:00am - Resident had a witnessed fall on 12/13/14 at 8pm when another Resident fall causing Resident to fall onto his/her knees and then his/her chin. This nurse received a call from Certified Medication Aide (CMA) on duty this morning stating Resident had blood coming from mouth and breathing was fast/hard with gurgling. This nurse instructed CMA to call 911 and family... vitals obtained... Resident left via gurney accompanied by ambulance personnel... contacted hospital staff... contacted family member and informed of fall over the weekend... family reported Resident admitted... brain bleed... may only live a day or two...

The medical record documentation lacked: Circumstances of the incident at the time of the

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S3261	Continued From page 12 incident, Actions taken and Resident's response to the actions, A licensed nurse assessment (physical status, injury location and description, orientation level, etc) of #185 completed at the time of the incident, Notification of family regarding fall or appearance of bruising on 12/14/14, Treatment, first aid rendered, or licensed nurse assessment of Resident when bruising to chin and knee observed on 12/14/14, Any followup monitoring or assessment of #185's condition in the hours or days following the incident and subsequent bruising. On 3/18/15 at 5:08pm, Executive Director #H and Health and Wellness Director #G confirmed no other documentation available for #185 in the medical record from 12/13/14 through 12/15/14. The Operator failed to ensure #185's medical record contained the documentation of all incidents, symptoms, other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions.	S3261		