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	N087075	A. BUILDING: _____ B. WING _____	R-C 10/19/2017

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{S 000}	INITIAL COMMENTS The following citation represents the revisit at the above named facility on 10-16-17, 10-17-17, 10-18-17 and 10-19-17.	{S 000}		
{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 identified a census of 77 residents. The sample included 6 residents. Based on record review, interview, and observations, for 1 (#2312) of 6 residents sampled, the administrator failed to ensure the licensed nurse provided or coordinated Health Care Services to address resident #2312's elopement risk. The licensed nurse failed to implement interventions to address the resident's elopement risk. For 5 (#2233, #2123, #2211, #2222, #2255) of 6 residents sampled, the administrator failed to ensure the licensed nurse provided and coordinated health care services to address the resident's fall risk. Findings included:	{S3155}		

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

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{S3155}	Continued From page 1 - Record review for resident #2312 on 10-17-17 revealed an admit date of 9-13-15 with diagnose of frontal temporal lobe dementia with psychosis, and anxiety. The Functional Capacity Screen (FCS) dated 12-12-16 recorded on 12-12-16 resident independent with ambulation, experienced short term memory loss, memory recall, long term memory loss, impaired decision making, wandering, and on 9-28-17 FCS identified resident experienced socially disruptive inappropriate behaviors. The Negotiated Service Agreement (NSA) dated 9-28-17 recorded resident independent with ambulation, may need occasional cueing to find direction and remember information. Has attitude, disturbances and emotional states create consistent difficulties that can only be modified in special settings and or with special plans. Judgment is always poor and constantly puts self at risk. The Health Service Plan (HSP) dated 12-12-16 and 9-28-17 recorded resident independent with mobility, transfers, has risk for falls/unsteadiness wandering, elopement, socially inappropriate disruptive behaviors, and impaired decision making. The HSP lacked interventions to address identified risks. The medical care provider notes dated 9-11-17 recorded visit for complaint of increased behaviors and exit seeking. Review of the wellness notes from 9-11-17 through last entry on 10-6-17 lacked documentation that resident exhibited exit seeking behaviors or had any behavioral	{S3155}		

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episodes. On 9-17-17 orders to increase Seroquel (antipsychotic) to 50 milligrams two times a day and may have one extra dose during day time as needed for increased behaviors/exit seeking.

Interview on 10-17-17 at 9:45 a.m. with certified staff J stated was in-serviced on elopement risk and what to do when a resident eloped. Certified staff J further stated (resident #2312) is an elopement risk and will try to get out doors but is easily redirected. Certified staff J also stated care plans are in the resident's charts in nursing station (outside of the memory care unit).

Interview on 10-17-17 at 10:10 a.m. with licensed nurse A stated resident had increased behaviors and exit seeking, doctor came to see resident, increased Seroquel (antipsychotic), and resident is better now.

On 10-17-17 at 10:15 a.m. observed resident #2312 walking very fast pace down hallway, cheerful mood, certified staff D walked with resident in assisted living area and then took resident back inside to memory care unit.

Interview on 10-16-17 at 3:55 p.m. with administrator and licensed nurse A stated they are working on health care plans and had focused on FCS and NSA's.

For resident #2312, the HSP lacked interventions for wandering, elopement, socially inappropriate disruptive behaviors, and impaired decision making.

- Record review for resident #2233 on 10-17-17 revealed an admit date of 11-1-14 with diagnoses of Parkinson's disease, dementia,

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hypothyroidism, and chronic urinary tract infection.

The FCS dated 9-5-17 recorded resident required physical assistance with bathing, dressing, toileting, transfer, unable to ambulate or walk, experienced short term memory loss, memory recall, long term memory loss, decision making, impaired decision making and falls/unsteadiness.

The NSA dated 9-5-17 recorded resident required physical assistance of one staff and staff to ask for additional help as needed, resident had falls last 90 days, one staff to transfer; do not leave in wheelchair in room; resident is not oriented to time, place, and cannot remember or use information. Resident required redirection and validation from staff. Resident's judgement is poor and needs supervision. Resident needs complete physical assistance to evacuate residence.

The HSP dated 9-5-17 and significant change HSP dated 10-13-17 recorded resident experienced falls/unsteadiness, impaired decision making, needs frequent checks, physical assist of one staff with gait belt for transfers, to and from wheelchair, bed, and recliner.

Observed faxed physician orders dated 9-18-17, 10-5-17 and 10-8-17 to inform physician resident had unwitnessed falls and with the fall on 10-5-17 resident experienced skin tear to left toe at the joint had 3.5 centimeter by 2.5 centimeter purple/red colored area.

The history and physical dated 10-19-17 recorded Chief Complaint: Repeated Falls. Resident has had 3 falls in last 4-5 days. Plan: Frequent falls-collaborated with facility nurse and hospice

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nurse about what next step in care would be. They will try to see if there is a trend with falls.

Wellness Notes recorded the following:

9-25-17 at 9:00 p.m. This nurse observed resident lying on floor in supine position. While assessing resident family member came into room. No injury noted. Time frame of falls tend to be between 2:30 to 5:00 p.m. and talked to family member about visiting around those times.

10-5-17 at 1:30 p.m. Resident had a fall at approximately 12:45 p.m. and was found on floor by staff. Head and back towards recliner. Observed red/purple area on left forearm, no other concerns.

10-8-17 at 1:45 p.m. resident had unwitnessed fall and was found on floor one half of body lying on floor on left side. Denied hitting head. Certified staff found resident on floor when doing visual check. No injuries noted.

10-15-17 at 7:25 p.m. Resident found on floor in living room and failed to use call button. Walker was in living room. No injuries noted.

The wellness notes lacked further documentation about falls.

The HSP lacked interventions for falls/unsteadiness and impaired cognition.

Interview on 10-17-17 at 2:00 p.m. with resident stated he/she gets up by-self without assistance and depending on the day will call for assistance. Resident also stated goes to the restroom by-self and does not like using walker. Observed walker and wheelchair in living room with resident as

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he/she was sitting in recliner. Resident was forgetful and unable to understand simple questions.

Interview on 10-17-17 at 2:10 p.m. with certified staff N stated to check on resident every thirty minutes. Certified staff N check electronic records; identified thirty minute checks, and confirmed nothing about falls in electronic record available to certified staff. Certified staff N further stated the HSP are downstairs in resident's chart in the nurses station. Certified staff N stated just knew to check on resident every thirty minutes to see if resident needed anything.

Interview on 10-17-17 at 2:20 p.m. with licensed nurse A confirmed the care plan did not have any fall interventions.

Interview on 10-17-17 at 3:00 with licensed nurse B stated and confirmed the HSP lacked any interventions for falls/unsteadiness and confirmed resident experienced impaired cognition.

For resident #2233, the HSP lacked interventions for cognitive impaired resident identified as a fall risk.

- Record review for resident #2211 on 10-16-17 at 2:50 p.m. revealed an admit date of 4-4-16 with diagnosis of dementia, acute renal failure, urinary retention, parathyroid disease, and prostate cancer.

The FCS dated 8-29-17 and reviewed on 9-27-17 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, eating, experienced short-term memory loss, long term memory loss, memory recall, decision making, falls/unsteadiness and socially disruptive

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inappropriate behaviors.

The NSA dated 9-27-17 recorded resident required two staff assist for mobility, transferring, bathing, resident is not oriented to time or place and cannot remember or use information, and needs complete physical assistance to evacuate residence.

The HSP dated 9-27-17 recorded resident required two staff assist with dressing, toileting, incontinent care, transfer, mobility, and short/long term memory.

The HSP lacked interventions for cognitive impaired resident identified at risk for falls and two person assist for mobility and transfer.

Wellness Notes recorded the following:
10-7-17 Resident had a non-injury fall and slid from recliner. Staff informed nurse who entered room at approximately 12:50 p.m. to find resident lying on floor with head on pillow. Staff denied getting pillow and the pillow was placed under resident's head. Resident able to follow commands and showed no signs of pain or discomfort.

10-9-17 at 4:00 p.m. Family here to discuss care for resident and talked about fall and intervention of moving remote to electronic chair and Velcro to back of chair.

On 10-16-17 at 1:10 p.m. observed resident #2211 leaning back in high back wheel chair. Resident sitting in dining room while other residents participating in activities. Resident #2211 unable to participate.

Interview on 10-16-17 at 1:15 p.m. with certified

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staff F stated resident is full lift and unable to assist. We need a hoyer lift and nurse to call hospice to bring one to facility. Resident is unable to stand or assist with anything. Resident is dependent for all care.

Interview on 10-17-17 at 3:30 p.m. with licensed nurse B stated resident has a sit to stand recliner and not sure who raised the chair to standing position. When investigated fall the chair was in standing position and resident was on the floor. The remote is to be kept in back of chair at all times. Licensed nurse B stated and confirmed the HSP lacked any interventions for cognitive impaired resident for falls/unsteadiness or that remote to electric chair to be kept in back of chair at all times.

The HSP lacked interventions for impaired cognitions, dependent for all care, falls/unsteadiness, and remote to stay in back of electric chair.

- Record review for resident #2255 on 10-17-17 revealed admit date of 10-13-14 with diagnoses of dementia with depression, hypertension, coronary artery disease, and mitral valve insufficiency.

The FCS dated 10-13-17 recorded resident required physical assistance with dressing, toileting, transfer, incontinence of bowel and bladder, unable to assist with walking/mobility, experienced short term memory loss, memory recall, decision making, impaired decision making, and falls/unsteadiness.

The NSA dated 10-13-17 recorded resident required physical assistance of one staff for mobility, transferring, dressing, toilet every two

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hours with verbal cueing, check every two hours and toilet at 11:00 a.m., 2:00 p.m., 5:00 p.m., 11:00 p.m., and 4:00 a.m. Resident required frequent orientation, and needs verbal reminding daily to orient to time and place. Resident has attitude, habits and emotional states do not create unusual demand on others. Judgement is always poor and constantly puts self at risk.

The HSP dated 10-13-17 recorded resident required physical assistance for bathing, dressing toileting, propelling wheelchair, standby assist with use of gait belt, required frequent orientation for cognitive/memory and communication.

The HSP lacked interventions for cognitive impaired resident at risk for falls/unsteadiness.

The house call medical services dated 10-2-17 recorded Chief Complaint: follow up on fall. Saw resident at request of staff due to fall several night ago and crawled on the ground to get back up.

Preliminary x-ray report on 10-5-17 at 8:29 a.m. revealed right clavical: No fracture in the clavicle. Chronic changes in the joint noted.

The wellness notes recorded the following:

9-30-17 at 4:39 a.m. observed resident was beside bed and had crawled from recliner in living room to bed. Resident was on knees and stated wanted to go to restroom. Resident has good range of motion. Resident has pea size abrasion on left middle toe. Resident was taken to toilet and observed pendant on neck; resident stated forgot to use it.

10-1-17 at 4:37 a.m. Resident on call light and

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this nurse entered room to find resident lying on floor on right lateral side at 4:40 a.m. Resident climbed out of bed, not injury noted, resident pleasant and confused.

10-5-17 at 3:30 a.m. Resident was found trying to transfer self from bed to wheelchair and was trying real hard to hold on. I assisted him/her to wheelchair and he/she stated wanted to go to restroom. Resident complained of pain in right shoulder. Resident wanted to stay up and watch TV. At 4:40 a.m. resident continued to complain of pain in right shoulder. Physician notified and radiology called for mobil x-ray of right shoulder.

10-6-17 at 2:36 p.m. questions answered from daughter about fall on floor in front of couch. Resident was sitting with back to couch in an upright position with feet pointing towards the bedroom. Resident stated I was trying to take myself to the restroom. No injuries noted.

10-14-17 at 10:00 a.m. on 10-13-17 resident moved to memory care unit.

On 10-17-17 at 2:30 p.m. observed resident participating in exercise activity while sitting in wheelchair.

Interview on 10-17-17 at 2:35 p.m. with certified staff F stated resident is not an elopement risk and required a two person transfer due to resident curling up during transfer.

Interview on 10-17-17 at 3:15 p.m. with licensed nurse B and administrator stated and confirmed the NSA/HSP lacked interventions for falls/unsteadiness.

For residents #2312,#2233, #2123, #2211,

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{S3155}	Continued From page 10 #2222, #2255, the administrator failed to ensure the licensed nurse provided and coordinated health care services to meet the needs of each resident in accordance with the functional capacity screen and negotiated service agreement.	{S3155}		