STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087082	A. BUILDING: _____ B. WING _____	10/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES SENIOR LIVING COMMUNITY	1400 S 183RD WEST GODDARD, KS 67052

(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 resurvey with complaint #127184 at the above named facility on 10/15/18, 10/16/18, 1/17/18, 10/24/18, 10/25/18, and 10/29/18.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1) The facility identified a census of 58 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview for 1 (#611) of 1 closed record review, the administrator failed to ensure the resident was not subjected to neglect when facility staff failed to follow the policy requiring notification of the nurse when a resident does not attend a meal. Resident #611 experienced a fall sometime before bedtime on 2/6/18 and was not found on the floor until noon on 2/7/18. Resident #611 experienced a hip fracture and was found on the floor crying and yelling out in pain. Findings included:	S3026		

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

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- Closed record review for resident #611 revealed an admit date of 9/30/17 with diagnoses of dementia, hypertension, anxiety, and depression.

The functional capacity screen dated 9/12/17 recorded resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, required supervision with medications, experienced occasional bladder incontinence, poor memory recall, impaired vision and hearing.

The negotiated service agreement (NSA)/health care service plan (HCSP) dated 9/30/17 recorded resident independent with bathing, dressing, toileting, walking/mobility, eating, supervision for management of medications, and treatments, experienced occasional bladder incontinence and assist upon request only, experienced memory recall, wears glasses for impaired vision and identified with impaired hearing.

Fall intervention care plan dated 11/25/17 recorded remind resident to request assistance for weakness/unsteady gait.

The nurse ' s notes recorded the following:

11/25/17 at 1:49 p.m. Resident used assistance device to alert staff he/she had fallen. Resident stated was bending over to put dog on the leash and lost balance. No injuries noted. Will continue to monitor. Signed licensed nurse G.

2/7/18 at 3:01 p.m. "(Family member) met this nurse in the hall outside resident's room and asked me to unlock door. (Family member) stated he/she could hear resident and he/she is not answering the door. Resident heard calling for help and found lying on back by bedroom door

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covered with a blanket. Resident reported had been there all night, resident not wearing call pendent that was located on bathroom sink counter. Resident denied head contact and reported pain to right leg. Right leg noted to be turned outward. Palpation to upper right leg and hip area induced pain, resident in severe pain with minimal movement. 911 called and transported resident to hospital for evaluation. Signed licensed nurse M.

Incident report dated 2/7/18 at 12:15 p.m. by licensed nurse M recorded resident was alone in room and stated "I have been on floor all night, my legs are not working."

Interview on 10/16/18 at 10:55 a.m. with licensed nurse A stated was here at time of incident on 2/7/18 at approximately 12:15 p.m. Licensed nurse M and certified staff L were in room along with family member. Resident was on the floor and licensed nurse M informed this nurse that resident stated he/she had fallen trying to go to the bathroom and resident was on floor all night. Resident complained of right hip pain. This nurse removed blanket that covered resident and resident verbally expressed pain due to movement of him/her where blanket was tucked under him/her. Right leg and foot laterally rotated. Resident was incontinent of urine.

Confidential interview stated resident had a doctor appointment at approximately 1:00 p.m. on 2/7/18 and upon arrival to resident ' s door could hear resident yelling for help. Staff (did not know who) unlocked door and observed resident on the floor crying and yelling out in pain. Resident stated, "I was praying all night and afraid I was going to die. I prayed for someone to come in and find me" Resident was crying while talking

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about being on the floor all night and complained of pain in right leg/foot. Resident was not wearing call pendent. Licensed nurse M was in room with resident. Licensed nurse A came to room later right before (Emergency Medical Technicians) EMT ' s arrived. Resident stated was on floor all night since bedtime about 10:00 p.m. and still had day clothes on. Resident took dog out that evening. "I noted resident had incontinent episode in clothes and he/she never did that. EMT ' s administered pain medication two times before moving resident. Resident missed breakfast and lunch, and no one came to check on him/her like they are supposed to if someone missed a meal." Licensed nurse A had put in place that if a resident missed a meal, nursing staff was to check on resident to make sure they were ok. "Well that didn ' t work and obviously was not in place."

10/15/18 at 12:30 p.m. Dietary Manager D provided copies of "No Meal Attendance Documentation". The Dietary Manager D stated licensed nurse implemented this form prior to him/her becoming Dietary Manager in December 2017. The "No Attendance Documentation Record" record had scribble marks through Resident #611 ' s name for the whole month of February 2018 but could identify check marks on 2/7/18 indicating resident ate breakfast and lunch in dining room and ate dinner in dining room on 2/6/18 the night before.

Interview on 10-15-18 at 12:15 p.m. with server N stated the "No Attendance Meal Documentation Record" has the name of all residents for breakfast, lunch, and dinner. If a resident does not come to meals the nurse is notified by the name written on the paper. If residents come to

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meals a check mark it put beside resident ' s name. Server N stated had been doing this for a long time.

Interview on 10/16/18 at 12:00 noon with certified staff L stated was working on 2/7/18 giving medications. Dining room staff called licensed nurse M to let them know resident did not come to breakfast and further stated did not see resident take dog outside this morning as he/she usually did. Certified staff L stated certified staff K did not see dog this morning, followed up with kitchen staff who also stated resident was not at breakfast this morning, so I went to resident room to check on him/her, and observed nursing staff with resident. (Emergency Medical Services) EMS arrived and I left room.

Interview on 10/16/18 at 1:10 p.m. with licensed nurse A stated did not have a policy and procedure for, "No Attendance Meal Documentation record."

Telephone interview on 10/16/18 at 3:10 p.m. with licensed nurse M stated "approximately 12:00 noon (resident ' s family member) came and got me to unlock door because resident was yelling for help. I unlocked door and observed resident on floor lying on back at end of bed. Resident ' s feet faced the bathroom. Resident was covered with a blanket he/she pulled off the bed during the night. Resident was crying out in pain while I pulled blanket off to assess him/her. Resident had an incontinent episode and still had day clothing on. Right leg and foot rotated outward and not same as left leg/foot. When I touched resident he/she cried out in pain. I then called 911 as it was obvious resident had a serious injury of right leg/foot. Resident stated he/she was on floor all night praying and yelling for help

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S3026	Continued From page 5 and was in pain. Resident was afraid no one would find him/her. Licensed nurse A came into room when I was assessing resident. When EMS arrived, they started asking licensed nurse A questions and then family member told them they needed to talk to this nurse as I was the one who found resident and took care of resident. Family member very upset. EMS administered fentanyl medication two times to resident prior to moving resident as he/she was in a lot of pain before they moved him/her." Review of the EMS report dated 2/7/18 documented the call was received at 12:28 p.m. and they had contact with the resident at 12:38 p.m. The report recorded "Patient stated (he/she) fell last night without (his/her) life alert device and was unable to get up and had to lay on the floor all night. Patient stated right hip hurt." At 12: 42 Fentanyl 50 micrograms (MCG) (for pain) administered. At 12:58 p.m. blood pressure (B/P) 171/70, pulse 83, respirations 16, PAIN: 8 (1 to 10 scale) 1 the least amount of pain and 10 worst pain (after first dose of Fentanyl). Second dose of Fentanyl 50 MCG administered at 1:05 p.m. for pain. Resident transported to hospital at 12:56 p.m. For resident #611, the administrator failed to ensure the resident was not subjected to neglect when facility staff failed to follow the policy requiring notification of the nurse when a resident does not attend a meal.	S3026		
S3028 SS=D	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	S3028		

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S3028	Continued From page 6 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 by: KAR 26-41-101(f)(3) The facility identified a census of 58 residents. The sample included 3 residents and 1 closed record review. Based on record review and interview for 1 (#611) of 1 closed record review, the administrator failed to ensure each allegation of neglect was reported to the department and investigated.	S3028		

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S3028	Continued From page 7 Findings included: - Closed record review for resident #611 revealed an admit date of 9/30/17 with diagnoses of dementia, hypertension, anxiety, and depression. The functional capacity screen dated 9/12/17 recorded resident independent with bathing, dressing, toileting, transfer, walking/mobility, eating, required supervision with medications, experienced occasional bladder incontinence, poor memory recall, impaired vision and hearing. The negotiated service agreement (NSA)/health care service plan (HCSP) dated 9/30/17 recorded resident independent with bathing, dressing, toileting, walking/mobility, eating, and supervision for management of medications, and treatments, experienced occasional bladder incontinence and assist upon request only, experienced memory recall, wears glasses for impaired vision and identified with impaired hearing. The nurse ' s notes recorded the following: 2/7/18 at 3:01 p.m. "(Family member) met this nurse in the hall outside resident's room and asked me to unlock door. (Family member) stated he/she could hear resident and he/she is not answering the door. Resident heard calling for help and found lying on back by bedroom door covered with a blanket. Resident reported had been on the floor all night, resident not wearing call pendent that was located on bathroom sink counter. Resident denied head contact and reported pain to right leg. Right leg noted to be turned outward. Palpation to upper right leg and hip area induced pain, resident in severe pain	S3028		

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with minimal movement. 911 called and transported resident to hospital for evaluation.

Confidential interview stated resident had a doctor appointment at approximately 1:00 p.m. on 2/7/18 and upon arrival to resident ' s door could hear resident yelling for help. Staff (did not know who) unlocked door and observed resident on the floor crying and yelling out in pain. Resident stated, "I was praying all night and afraid I was going to die. I prayed for someone to come in and find me" Resident was crying while talking about being on the floor all night and complained of pain in right leg/foot. Resident was not wearing call pendent. Resident stated was on floor all night since bedtime about 10:00 p.m. and still had day clothes on. Resident took dog out that evening. Resident missed breakfast and lunch, and no one came to check on him/her like they are supposed to if someone missed a meal. Licensed nurse A had put in place that if a resident missed a meal, nursing staff was to check on resident to make sure they were ok. "Well that didn ' t work and obviously was not in place."

10/15/18 at 12:30 p.m. Dietary Manager D provided copies of "No Meal Attendance Documentation". The Dietary Manager D stated licensed nurse implemented this form prior to him/her becoming Dietary Manager in December 2017. The "No Attendance Documentation Record" recorded had scribble marks through Resident #611 ' s name for the whole month of February 2018 but could identify check marks on 2/7/18 indicating resident ate breakfast and lunch in dining room and ate dinner in dining room on 2/6/18 the night before.

Interview on 10/16/18 at 12:00 noon with certified

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S3028	Continued From page 9 staff L stated was working on 2/7/18 giving medications. Dining room staff called licensed nurse M to let them know resident did not come to breakfast and further stated did not see resident take dog outside this morning as he/she usually did. Certified staff L stated certified staff K did not see dog this morning, followed up with kitchen staff who also stated resident was not at breakfast this morning, so I went to resident room to check on him/her, and observed nursing staff with resident. (Emergency Medical Services) EMS arrived and I left room. Incident report dated 2/7/18 at 12:15 p.m. by licensed nurse M recorded resident was alone in room and stated "I have been on floor all night, my legs are not working." The documentation regarding the incident failed to address the inaccuracy of the "No Attendance Documentation Record" and failed to verify if the licensed nurse was notified of the resident not coming to breakfast. Review of Department records show the incident was not reported to the department. For resident #611, the administrator failed to ensure each allegation of neglect was reported to the department and investigated.	S3028		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every	S3092		

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S3092	Continued From page 10 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: 26-41-102 (d)(2) The facility identified a census of 58 residents. The sample included 3 residents and 1 closed record review. Based on record review, interview and observation for 2 of 3 sampled residents (#644, and #633) the administrator failed to ensure the revision of the negotiated service agreement with a significant change in condition. - Record review for resident #644 recorded an admit date of 8/19/16 with diagnoses of hypertension, depression, and arteriosclerotic heart disease. The annual functional capacity screen (FCS) dated 8/1/17 recorded resident independent with toileting, transfer, walking/mobility, eating, required supervision with bathing, dressing, bladder incontinence, physical assistance for management of medications/treatments, experienced short-term memory loss, memory recall, impaired vision, and impaired hearing.	S3092		

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S3092	Continued From page 11 The resident did not experience falls/unsteadiness. The annual negotiated service agreement (NSA)/health care service plan (HCSP) dated 8/1/17 recorded resident independent with toileting, transfers, walking/mobility, eating, required supervision with bathing, dressing, physical assistance with management of medications/treatments, incontinent care, experienced short-term memory loss, memory recall, impaired vision wears glasses, hard of hearing and wears hearing aide in left ear. Mobility devices: Walker, Mechanical lift chair. Additional care instructions: Staff to ensure resident stays on task while dressing to ensure resident attends lunch. Monitor trash cans for laundry and laundry basket for trash due to resident throwing away laundry due to placing it in the wrong location. Resident typically attends two meals per day (lunch and supper) due to current sleep schedule. The progress notes recorded the following: 1/7/18 at 4:30 a.m. Resident called staff to room when staff arrived resident was laying on left hip on floor next to bed. When staff asked what happened resident stated was sitting on side of bed when slid off. Resident put back to bed and reminded to call when needed help. Signed licensed nurse Q. 1/7/18 at 3:51 p.m. Resident complained of right hip pain when attempting to sit early this morning. Resident wincing in pain. The nurse spoke with	S3092		

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family and order was obtained to get an x-ray. X-ray obtained and resulted with slight valgur angulation potentially due to fracture, but x-ray read if continued pain considers CT-scan or MRI. Resident assisted to bathroom and assisted to get dressed this morning. No complaint of pain at this time. Signed licensed nurse R.

1/8/18 at 5:44 p.m. Resident found by housekeeping around 9:50 a.m. nearly falling off bed. This nurse and staff went into room. Resident leaning to left side and unable to sit up without assistance. Blood Pressure (B/P) 99/56, Pulse (P) 95, Temperature (T) 97.3. When staff attempted to stand resident, he/she continued to lean to left side. EMS notified. Resident wincing upon sitting when fire department attempted to stand resident. EMS transferred resident to hospital. Signed licensed nurse R.

The significant change FCS dated 1/29/18 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments, incontinent of bladder control, experienced short-term memory loss, memory recall, decision-making, experienced impaired vision, impaired hearing, and falls/unsteadiness.

2/2/18 at 10:45 a.m. resident returned to facility and family present. A home health aide arrived and assisted resident to dining room. Signed licensed nurse O.

2/2/18 at 10:30 p.m. Resident had sitter entire

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S3092	Continued From page 13 shift and ate dinner. Swallowed all medications without difficulty. Family present most of shift. Signed licensed nurse M. 2/3/18 at 4:09 p.m. Resident transferring well with one assist, needing constant reminders to not apply weight to right leg. Caregiver present in room. Signed licensed nurse R. 2/4/18 at 1:47 p.m. Sitter present in room and assist with calling for help when needed. Continue to remind resident not to put weight on right leg. Signed licensed nurse R. 2/7/18 at 11:33 a.m. Sitter alerted this nurse regarding a sore to resident ' s right heel. Resident has a pressure sore measuring 6 centimeters (CM) by 7 CM and pitting edema to both feet. This nurse call physician and left message to return call. Signed licensed nurse G. The record lacked revision of the NSA with a significant change and the use of an outside provider until 3/1/18. The significant change NSA/HCSP dated 3/1/18 recorded resident required physical assistance of one to two staff for bathing, dressing, and toileting. Transfers required physical assistance of two staff, gait belt, and us of electric lift chair. For walking/mobility required physical assistance of one staff to propel in wheelchair. Resident independent with eating. Facility staff to administer medications and manage wound care.	S3092		

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	N087082	A. BUILDING: _____ B. WING _____	10/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES SENIOR LIVING COMMUNITY	1400 S 183RD WEST GODDARD, KS 67052

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S3092	Continued From page 14 Resident frequently incontinent and require assistance with dressing, perineal care, and assistance with transfer. Resident occasionally incontinent of bowels and require assistance with perineal care, assist with changing clothes and transfer. Resident has short-term memory loss, poor memory recall, and decision making. Resident has falls/unsteadiness, poor eye sight, and hard of hearing. May use wheelchair or mechanical lift or recliner. Additional comments: Shower chair present and is required to be used due to weakness. Encourage resident to wash areas of body he/she can reach while nursing staff washes all other areas. Resident tis to be encouraged to ambulate as tolerated in and outside of resident room. Family request that resident be encouraged to eat a variety of food and not only a hamburger and fries every day because that is what he/she remembers to eat. Required transportation for medical reasons will be provided by facility or coordinated through contracted company at family ' s request. Interview on 10/17/18 at 1:05 p.m. with licensed nurse O stated resident #644 returned from rehab due to fall with fractured hip and had to have a sitter twenty-four hours a day seven days a week. Resident is a two-person transfer. Interview on 10/17/18 at 1:40 p.m. with resident stated he/she ambulated by self, dresses self, goes to restroom by self and did not need assistance. Observed a gait belt around his/her waist and asked what that was for and he/she stated did not know what it was. Resident was sitting in chair. Surveyor asked if he/she ate lunch and he/she stated no	S3092		

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S3092	Continued From page 15 and was hungry. Interview on 10/17/18 at 1:45 p.m. with certified staff L state resident at lunch in dining room and had just got back to room. Resident is unable to get up by self and will call using the call pendant if wants to get up. Resident required two staff assist for transfer and ambulation. Is not using hoyer lift at this time but after he/she returned from rehab was using the hoyer lift. For resident #644, the administrator failed to ensure revision of the NSA with a significant change in condition. - Record review for resident #633 revealed an admit date of 2/28/14 with diagnoses of arthritis, seizures, atrial fibrillation, hypertension, and spinal stenosis. The annual functional capacity screen dated (FCS) 2/27/18 recorded resident independent with eating, required supervision with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments, bladder incontinence, experienced short-term memory loss, memory/recall, impaired vision, hard of hearing, and falls/unsteadiness. The negotiated service agreement (NSA)/health care service plan (HCSP) dated 2/27/18 recorded resident required supervision by nursing staff and spouse for bathing dressing, toileting, transfers,	S3092		

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S3092	Continued From page 16 walking/mobility, management of medications/treatments. Resident is incontinent of bladder and independent in care. The resident progress notes document a fall on 9/10/18 when the plastic chair the resident was sitting in fell over as he/she was scooting the chair out. The fall resulted in a hip fracture. The resident progress notes recorded the following: 9/12/18 at 11:09 p.m. Resident returned to facility and adjusting well. Signed licensed nurse R. 9/12/18 CT scan of right hip final report findings: There is a right greater trochanteric fracture which is mildly displaced. The is no additional acute fractures noted. 9/13/18 at 12:50 p.m. Staff went in and checked on resident. Resident was sitting in recliner and was incontinent of urine. Three staff helped resident up and to the restroom. Staff encouraged resident to use call light when needing any help. Signed licensed nurse O. 9/13/18 at 9:26 p.m. Resident using call pendant for assistance and required two staff assist with transfers. Signed licensed nurse Q. The record continued to document the need for two staff to assist with transfers through the	S3092		

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S3092	Continued From page 17 month of September 2018. The record lacked a revision of the NSA with a significant change in condition. Interview at 3:45 p.m. on 10/16/18 with resident #633 stated fell and broke right hip. Resident stated does get up by self without help, then stated no weight bearing on right leg due to broken hip and right foot hurts too. Resident further stated, dressed self, and transfers self to wheelchair. Resident #635 (family member) stated he/she dressed, toileted, transferred resident #633 because he/she could not dress self, transfer self or stand on right leg. Interview at 4:05 p.m. on 10/16/18 with certified staff B stated resident used to be independent until last fall with broken hip and now required physical assistance with all ADL ' s and is dependent on staff for transfers. Interview at 4:15 p.m. on 10/16/18 with licensed nurse P state he/she was not aware that resident ' s (family member #635) was assisting resident #633 with transfer, dressing, and toileting. Interview on 10/16/18 at 4:30 p.m. with licensed nurse A stated and confirmed the FCS, NSA/HCSP did not reflect resident ' s needs for fractured hip. For resident #633, the administrator failed to ensure the revision of the negotiated service	S3092		

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S3092	Continued From page 18 agreement with a significant change in condition.	S3092		
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 58 residents. The sample included 3 residents and 1 closed record review. Based on record review, interview and observation for 2 of 3 sampled residents (#644, and #633) the licensed nurse failed to provide and coordinate health care services to meet the needs of the residents. - Record review for resident #644 recorded an admit date of 8/19/16 with diagnoses of hypertension, depression, and arteriosclerotic heart disease. The annual functional capacity screen (FCS) dated 8/1/17 recorded resident independent with toileting, transfer, walking/mobility, eating, required supervision with bathing, dressing, bladder incontinence, physical assistance for	S3155		

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S3155	Continued From page 19	S3155		

management of medications/treatments, experienced short-term memory loss, memory recall, impaired vision, and impaired hearing. The resident did not experience falls/unsteadiness.

The annual negotiated service agreement (NSA)/health care service plan (HCSP) dated 8/1/17 recorded resident independent with toileting, transfers, walking/mobility, eating, required supervision with bathing, dressing, physical assistance with management of medications/treatments, incontinent care, experienced short-term memory loss, memory recall, impaired vision wears glasses, hard of hearing and wears hearing aide in left ear. Mobility devices: Walker, Mechanical lift chair. Additional care instructions: Staff to ensure resident stays on task while dressing to ensure resident attends lunch. Monitor trash cans for laundry and laundry basket for trash due to resident throwing away laundry due to placing it in the wrong location. Resident typically attends two meals per day (lunch and supper) due to current sleep schedule.

Mobil x-ray results dated 9/18/18 and compare to x-ray on 1/7/18 findings: abnormal displacement of the femoral head which appears to be rotated medially and inferiorly within the joint space.

The progress notes recorded the following:

1/7/18 at 4:30 a.m. Resident called staff to room when staff arrived resident was laying on left hip on floor next to bed. When staff asked what happened resident stated was sitting on side of bed when slid off. Resident put back to bed and reminded to call when needed help. Signed licensed nurse Q.

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S3155	Continued From page 20 1/7/18 at 3:51 p.m. Resident complained of right hip pain when attempting to sit early this morning. Resident wincing in pain. The nurse spoke with family and order was obtained to get an x-ray. X-ray obtained and resulted with slight valgur angulation potentially due to fracture, but x-ray read if continued pain considers CT-scan or MRI. Resident assisted to bathroom and assisted to get dressed this morning. No complaint of pain at this time. Signed licensed nurse R. Mobil x-ray results dated 1/7/18 recorded exam indication: pain after fall. Findings: impacted valgus-type femoral neck fracture right hip. The NSA/HCSP lacked interventions to address fall risk. 1/8/18 at 5:44 p.m. Resident found by housekeeping around 9:50 a.m. nearly falling off bed. This nurse and staff went into room. Resident leaning to left side and unable to sit up without assistance. Blood Pressure (B/P) 99/56, Pulse (P) 95, Temperature (T) 97.3. When staff attempted to stand resident, he/she continued to lean to left side. EMS notified. Resident wincing upon sitting when fire department attempted to stand resident. EMS transferred resident to hospital. Signed licensed nurse R. The significant change FCS dated 1/29/18 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments, incontinent of bladder control, experienced short-term memory loss, memory recall, decision-making, experienced impaired vision, impaired hearing, and falls/unsteadiness.	S3155		

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S3155	Continued From page 21 The NSA/HCSP lacked interventions to address physical assistance with bathing, dressing, toileting, transfers, walking/mobility and fall risk. 2/2/18 at 10:45 a.m. resident returned to facility and family present. A home health aide arrived and assisted resident to dining room. Signed licensed nurse O. 2/2/18 at 10:30 p.m. Resident had sitter entire shift and ate dinner. Swallowed all medications without difficulty. Family present most of shift. Signed licensed nurse M. 2/3/18 at 4:09 p.m. Resident transferring well with one assist, needing constant reminders to not apply weight to right leg. Caregiver present in room. Signed licensed nurse R. 2/4/18 at 1:47 p.m. Sitter present in room and assist with calling for help when needed. Continue to remind resident not to put weight on right leg. Signed licensed nurse R. The NSA/HCSP lacked interventions to address responsibilities of personal care giver and risks associated with immobility. 2/7/18 at 11:33 a.m. Sitter alerted this nurse regarding a sore to resident's right heel. Resident has a pressure sore measuring 6 centimeters (CM) by 7 CM and pitting edema to both feet. This nurse call physician and left message to return call. Signed licensed nurse G. The NSA/HCSP lacked revision to address interventions to promote wound healing and decrease risk for further skin breakdown.	S3155		

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S3155	Continued From page 22	S3155		

The significant change NSA/HCSP dated 3/1/18 recorded resident required physical assistance of one to two staff for bathing, dressing, and toileting. Transfers required physical assistance of two staff, gait belt, and us of electric lift chair. For walking/mobility required physical assistance of one staff to propel in wheelchair. Resident independent with eating. Facility staff to administer medications and manage wound care. Resident frequently incontinent and require assistance with dressing, perineal care, and assistance with transfer. Resident occasionally incontinent of bowels and require assistance with perineal care, assist with changing clothes and transfer. Resident has short-term memory loss, poor memory recall, and decision making. Resident has falls/unsteadiness, poor eye sight, and hard of hearing. May use wheelchair or mechanical lift or recliner.

The revised NSA/HCSP continued to lack interventions to promote wound healing and decrease risk for further skin breakdown.

3/2/18 at 11:19 p.m. This nurse along with certified staff S put resident to bed at 10:30 p.m. Resident no longer has a sitter and resident was still awake in day clothes. This nurse advised resident to call for help when needed and not to get up without help. This nurse also put resident's flash light underneath pillow. Signed licensed nurse G.

3/3/18 at 10:29 a.m. Resident called at 6:45 a.m. and was found sitting on floor in front of bed. Resident stated, "slid out of bed". Resident denied pain and assisted to standing with two staff. Signed licensed nurse G.

3/5/18 at 8:09 a.m. Housekeeper let this nurse

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S3155	Continued From page 23	S3155		

know that resident had fallen at 7:20 a.m. When nurse arrived at resident's room, he/she was sitting on the floor in front of bed. Resident stated was walking back from bathroom, missed bed when he/she went to sit on it and hit the floor. No injuries noted. Signed licensed nurse O.

The NSA/HCSP lacked interventions to address this cognitively impaired resident's continued fall risk.

3/25/18 at 3:00 p.m. Resident had frequent times where he/she was ambulating by self. Resident was reminded to use pendent button to call for assistance. Signed licensed nurse T.

3/29/18 at 5:16 p.m. Resident's heel much improved. Right heel with pink skin covering wound bed. No open areas remain. Measurement of pink skin 2 CM round. Signed licensed nurse R.

3/30/18 at 2:53 p.m. Resident used call pendant and was found on floor in doorway in between bedroom and living room. Resident laying on left side. Denied pain. Assisted to standing position with assist of 2 staff. Assisted resident to recliner. Resident stated, "I got awkward and my feet tripped over each other." Resident stated was walking back from bathroom. Reminded resident to use call pendant. Signed licensed nurse R.

The NSA/HCSP continued to lack appropriate interventions to address this cognitively impaired resident's risk for falls and to address risk for skin breakdown.

The resident experienced falls on 5/5/18, 5/9/18, 5/18/18.

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S3155	Continued From page 24 6/21/18 at 9:51 a.m. This nurse noticed resident had a sore on right heel. Physician notified. Signed licensed nurse T. The NSA/HCSP continued to lack interventions to address fall risk and interventions to promote wound healing and prevent further skin breakdown. Interview on 10/17/18 at 1:05 p.m. with licensed nurse O stated resident #644 returned from rehab due to fall with fractured hip and had to have a sitter twenty-four hours a day seven days a week. Resident is a two-person transfer. Interview on 10/17/18 at 1:40 p.m. with resident stated he/she ambulated by self, dresses self, goes to restroom by self and did not need assistance. Observed a gait belt around his/her waist and asked what that was for and he/she stated did not know what it was. Resident was sitting in chair. Surveyor asked if he/she ate lunch and he/she stated no and was hungry. Interview on 10/17/18 at 1:45 p.m. with certified staff L state resident at lunch in dining room and had just got back to room. Resident is unable to get up by self and will call using the call pendant if wants to get up. Resident required two staff assist for transfer and ambulation. Is not using hoyer lift at this time but after he/she returned from rehab was using the hoyer lift. For resident #644, the licensed nurse failed to provide and coordinate health care services to meet the needs of this cognitively impaired resident.	S3155		

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S3155	Continued From page 25 - Record review for resident #633 revealed an admit date of 2/28/14 with diagnoses of arthritis, seizures, atrial fibrillation, hypertension, and spinal stenosis. The annual functional capacity screen dated (FCS) 2/27/18 recorded resident independent with eating, required supervision with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments, bladder incontinence, experienced short-term memory loss, memory/recall, impaired vision, hard of hearing, and falls/unsteadiness. The negotiated service agreement (NSA)/health care service plan (HCSP) dated 2/27/18 recorded resident required supervision by nursing staff and spouse for bathing dressing, toileting, transfers, walking/mobility, management of medications/treatments. Resident is incontinent of bladder and independent in care. For cognition has short-term memory loss and memory recall. Problems and risks resident has had are falls/unsteadiness. Mobility devices used are a walker. Fall intervention care plan: re-orient to use call pendent and remove plastic chairs in room. The resident progress notes recorded the following: 9/10/18 at 9:06 a.m. Resident #635 (family member) used call pendent around 8:40 a.m. to alert staff of resident #633 falling. Resident #633 stated was sitting at the kitchen table in a plastic chair and tried scooting the chair out and fell over. Resident stated he/she hit head on the floor and landed on right leg/hip area. Staff went to help resident up to feet and was very weak and	S3155		

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could not walk. Staff got a wheelchair and assisted resident to recliner. Blood Pressure (B/P) 157/75, Pulse (P) 75, Temperature (T) 97.5. This nurse called physician and got a STAT order for an x-ray for right femur. Signed licensed nurse O.

9/10/18 at 5:34 p.m. . . . At 4:40 p.m. doctor called this nurse and instructed to send resident to hospital because resident had a fracture and would have a bed waiting for resident at hospital. Emergency Medical Services (EMS) notified and this nurse helped resident pack. Resident #635 (family member) decided to stay at facility and would notify family. Resident left by EMS around 5:00 p.m. Signed licensed nurse P.

9/12/18 at 11:09 p.m. Resident returned to facility and adjusting well. Signed licensed nurse R.

9/12/18 CT scan of right hip final report findings: There is a right greater trochanteric fracture which is mildly displaced. The is no additional acute fractures noted.

9/13/18 at 12:50 p.m. Staff went in and checked on resident. Resident was sitting in recliner and was incontinent of urine. Three staff helped resident up and to the restroom. Staff encouraged resident to use call light when needing any help. Signed licensed nurse O.

9/13/18 at 9:26 p.m. Resident using call pendant for assistance and required two staff assist with transfers. Signed licensed nurse Q.

Documentation through September 2018 continued to identify that two staff were required to assist with transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087082	A. BUILDING: _____ B. WING _____	10/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES SENIOR LIVING COMMUNITY	1400 S 183RD WEST GODDARD, KS 67052

(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
S3155	Continued From page 27 10/12/18 at 6:25 a.m. This nurse assisted resident with shower and asked if resident if needed assistance with dressing and resident stated, "If I need help, (resident #635 family member) can help me." Signed licensed nurse R. Interview at 3:45 p.m. on 10/16/18 with resident #633 stated fell and broke right hip. Resident stated does get up by self without help, then stated no weight bearing on right leg due to broken hip and right foot hurts too. Resident further stated, dressed self, and transfers self to wheelchair. Resident #635 (family member) stated he/she dressed, toileted, transferred resident #633 because he/she could not dress self, transfer self or stand on right leg. The only help resident #635 (family member) did not provide was a shower because he/she felt like he/she was not comfortable to do that and may drop him/her. Resident #635 will call for help if resident #633 needed assistance. Interview at 4:05 p.m. on 10/16/18 with certified staff B stated resident used to be independent until last fall with broken hip and now required physical assistance with all ADL's and is dependent on staff for transfers. Interview at 4:15 p.m. on 10/16/18 with licensed nurse P state he/she was not aware that resident's (family member #635) was assisting resident #633 with transfer, dressing, and toileting. Interview on 10/16/18 at 4:30 p.m. with licensed nurse A stated and confirmed the NSA/HCSP did not reflect resident's needs for fractured hip. The NSA/HCSP lacked interventions for staff to provide care and services for fractured right hip	S3155		

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S3155	Continued From page 28 and lacked a description of the health care services to be provided by resident #635 (family member) who stated transferred resident and provided care and services. For resident #633, the licensed nurse failed to provide and coordinate health care services to meet the needs of the resident.	S3155		
S3156 SS=E	26-41-204 (b) Health Care Services (b) If the functional capacity screening indicates that a resident is in need of health care services, a licensed nurse, in collaboration with the resident, the resident ' s legal representative, the case manager, and, if agreed to by the resident or resident ' s legal representative, the resident ' s family, shall develop a health care service plan to be included as part of the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (a) The facility identified a census of 58 residents. The sample included 3 residents and 1 closed record review. Based on record review, interview and observation for 2 of 3 sampled residents (#644, and #633) the licensed nurse failed to provide and coordinate health care services to meet the needs of the residents.	S3156		

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S3156	Continued From page 29 - Record review for resident #644 recorded an admit date of 8/19/16 with diagnoses of hypertension, depression, and arteriosclerotic heart disease. The annual functional capacity screen (FCS) dated 8/1/17 recorded resident independent with toileting, transfer, walking/mobility, eating, required supervision with bathing, dressing, bladder incontinence, physical assistance for management of medications/treatments, experienced short-term memory loss, memory recall, impaired vision, and impaired hearing. The resident did not experience falls/unsteadiness. The annual negotiated service agreement (NSA)/health care service plan (HCSP) dated 8/1/17 recorded resident independent with toileting, transfers, walking/mobility, eating, required supervision with bathing, dressing, physical assistance with management of medications/treatments, incontinent care, experienced short-term memory loss, memory recall, impaired vision wears glasses, hard of hearing and wears hearing aide in left ear. Mobility devices: Walker, Mechanical lift chair. Additional care instructions: Staff to ensure resident stays on task while dressing to ensure resident attends lunch. Monitor trash cans for laundry and laundry basket for trash due to resident throwing away laundry due to placing it in the wrong location. Resident typically attends two meals per day (lunch and supper) due to current sleep schedule. Mobil x-ray results dated 9/18/18 and compare to	S3156		

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S3156	Continued From page 30 x-ray on 1/7/18 findings: abnormal displacement of the femoral head which appears to be rotated medially and inferiorly within the joint space. The progress notes recorded the following: 1/7/18 at 4:30 a.m. Resident called staff to room when staff arrived resident was laying on left hip on floor next to bed. When staff asked what happened resident stated was sitting on side of bed when slid off. Resident put back to bed and reminded to call when needed help. Signed licensed nurse Q. 1/7/18 at 3:51 p.m. Resident complained of right hip pain when attempting to sit early this morning. Resident wincing in pain. The nurse spoke with family and order was obtained to get an x-ray. X-ray obtained and resulted with slight valgur angulation potentially due to fracture, but x-ray read if continued pain considers CT-scan or MRI. Resident assisted to bathroom and assisted to get dressed this morning. No complaint of pain at this time. Signed licensed nurse R. Mobil x-ray results dated 1/7/18 recorded exam indication: pain after fall. Findings: impacted valgus-type femoral neck fracture right hip. The NSA/HCSP lacked interventions to address fall risk. 1/8/18 at 5:44 p.m. Resident found by housekeeping around 9:50 a.m. nearly falling off	S3156		

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S3156	Continued From page 31	S3156		

bed. This nurse and staff went into room. Resident leaning to left side and unable to sit up without assistance. Blood Pressure (B/P) 99/56, Pulse (P) 95, Temperature (T) 97.3. When staff attempted to stand resident, he/she continued to lean to left side. EMS notified. Resident wincing upon sitting when fire department attempted to stand resident. EMS transferred resident to hospital. Signed licensed nurse R.

The significant change FCS dated 1/29/18 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments, incontinent of bladder control, experienced short-term memory loss, memory recall, decision-making, experienced impaired vision, impaired hearing, and falls/unsteadiness.

The NSA/HCSP lacked interventions to address physical assistance with bathing, dressing, toileting, transfers, walking/mobility and fall risk.

2/2/18 at 10:45 a.m. resident returned to facility and family present. A home health aide arrived and assisted resident to dining room. Signed licensed nurse O.

2/2/18 at 10:30 p.m. Resident had sitter entire shift and ate dinner. Swallowed all medications without difficulty. Family present most of shift. Signed licensed nurse M.

2/3/18 at 4:09 p.m. Resident transferring well with

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S3156	Continued From page 32	S3156		

one assist, needing constant reminders to not apply weight to right leg. Caregiver present in room. Signed licensed nurse R.

2/4/18 at 1:47 p.m. Sitter present in room and assist with calling for help when needed. Continue to remind resident not to put weight on right leg. Signed licensed nurse R.

The NSA/HCSP lacked interventions to address responsibilities of personal care giver and risks associated with immobility.

2/7/18 at 11:33 a.m. Sitter alerted this nurse regarding a sore to resident ' s right heel. Resident has a pressure sore measuring 6 centimeters (CM) by 7 CM and pitting edema to both feet. This nurse call physician and left message to return call. Signed licensed nurse G.

The NSA/HCSP lacked revision to address interventions to promote wound healing and decrease risk for further skin breakdown.

The significant change NSA/HCSP dated 3/1/18 recorded resident required physical assistance of one to two staff for bathing, dressing, and toileting. Transfers required physical assistance of two staff, gait belt, and us of electric lift chair. For walking/mobility required physical assistance of one staff to propel in wheelchair. Resident independent with eating. Facility staff to administer medications and manage wound care. Resident frequently incontinent and require assistance with dressing, perineal care, and

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S3156	Continued From page 33 assistance with transfer. Resident occasionally incontinent of bowels and require assistance with perineal care, assist with changing clothes and transfer. Resident has short-term memory loss, poor memory recall, and decision making. Resident has falls/unsteadiness, poor eye sight, and hard of hearing. May use wheelchair or mechanical lift or recliner. The revised NSA/HCSP continued to lack interventions to promote wound healing and decrease risk for further skin breakdown. 3/2/18 at 11:19 p.m. This nurse along with certified staff S put resident to bed at 10:30 p.m. Resident no longer has a sitter and resident was still awake in day clothes. This nurse advised resident to call for help when needed and not to get up without help. This nurse also put resident ' s flash light underneath pillow. Signed licensed nurse G. 3/3/18 at 10:29 a.m. Resident called at 6:45 a.m. and was found sitting on floor in front of bed. Resident stated, "slid out of bed". Resident denied pain and assisted to standing with two staff. Signed licensed nurse G. 3/5/18 at 8:09 a.m. Housekeeper let this nurse know that resident had fallen at 7:20 a.m. When nurse arrived at resident ' s room, he/she was sitting on the floor in front of bed. Resident stated was walking back from bathroom, missed bed when he/she went to sit on it and hit the floor. No injuries noted. Signed licensed nurse O.	S3156		

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S3156	Continued From page 34 The NSA/HCSP lacked interventions to address this cognitively impaired resident ' s continued fall risk. 3/25/18 at 3:00 p.m. Resident had frequent times where he/she was ambulating by self. Resident was reminded to use pendent button to call for assistance. Signed licensed nurse T. 3/29/18 at 5:16 p.m. Resident ' s heel much improved. Right heel with pink skin covering wound bed. No open areas remain. Measurement of pink skin 2 CM round. Signed licensed nurse R. 3/30/18 at 2:53 p.m. Resident used call pendant and was found on floor in doorway in between bedroom and living room. Resident laying on left side. Denied pain. Assisted to standing position with assist of 2 staff. Assisted resident to recliner. Resident stated, "I got awkward and my feet tripped over each other." Resident stated was walking back from bathroom. Reminded resident to use call pendant. Signed licensed nurse R. The NSA/HCSP continued to lack appropriate interventions to address this cognitively impaired resident ' s risk for falls and to address risk for skin breakdown. The resident experienced falls on 5/5/18, 5/9/18, 5/18/18.	S3156		

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S3156	Continued From page 35 6/21/18 at 9:51 a.m. This nurse noticed resident had a sore on right heel. Physician notified. Signed licensed nurse T. The NSA/HCSP continued to lack interventions to address fall risk and interventions to promote wound healing and prevent further skin breakdown. Interview on 10/17/18 at 1:05 p.m. with licensed nurse O stated resident #644 returned from rehab due to fall with fractured hip and had to have a sitter twenty-four hours a day seven days a week. Resident is a two-person transfer. Interview on 10/17/18 at 1:40 p.m. with resident stated he/she ambulated by self, dresses self, goes to restroom by self and did not need assistance. Observed a gait belt around his/her waist and asked what that was for and he/she stated did not know what it was. Resident was sitting in chair. Surveyor asked if he/she ate lunch and he/she stated no and was hungry. Interview on 10/17/18 at 1:45 p.m. with certified staff L state resident at lunch in dining room and had just got back to room. Resident is unable to get up by self and will call using the call pendant if wants to get up. Resident required two staff assist for transfer and ambulation. Is not using hoyer lift at this time but after he/she returned from rehab was using the hoyer lift. For resident #644, the licensed nurse failed to	S3156		

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S3156	Continued From page 36 provide and coordinate health care services to meet the needs of this cognitively impaired resident. - Record review for resident #633 revealed an admit date of 2/28/14 with diagnoses of arthritis, seizures, atrial fibrillation, hypertension, and spinal stenosis. The annual functional capacity screen dated (FCS) 2/27/18 recorded resident independent with eating, required supervision with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments, bladder incontinence, experienced short-term memory loss, memory/recall, impaired vision, hard of hearing, and falls/unsteadiness. The negotiated service agreement (NSA)/health care service plan (HCSP) dated 2/27/18 recorded resident required supervision by nursing staff and spouse for bathing dressing, toileting, transfers, walking/mobility, management of medications/treatments. Resident is incontinent of bladder and independent in care. For cognition has short-term memory loss and memory recall. Problems and risks resident has had are falls/unsteadiness. Mobility devices used are a walker. Fall intervention care plan: re-orient to use call pendent and remove plastic chairs in room. The resident progress notes recorded the following:	S3156		

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S3156	Continued From page 37 9/10/18 at 9:06 a.m. Resident #635 (family member) used call pendent around 8:40 a.m. to alert staff of resident #633 falling. Resident #633 stated was sitting at the kitchen table in a plastic chair and tried scooting the chair out and fell over. Resident stated he/she hit head on the floor and landed on right leg/hip area. Staff went to help resident up to feet and was very weak and could not walk. Staff got a wheelchair and assisted resident to recliner. Blood Pressure (B/P) 157/75, Pulse (P) 75, Temperature (T) 97.5. This nurse called physician and got a STAT order for an x-ray for right femur. Signed licensed nurse O. 9/10/18 at 5:34 p.m. . . . At 4:40 p.m. doctor called this nurse and instructed to send resident to hospital because resident had a fracture and would have a bed waiting for resident at hospital. Emergency Medical Services (EMS) notified and this nurse helped resident pack. Resident #635 (family member) decided to stay at facility and would notify family. Resident left by EMS around 5:00 p.m. Signed licensed nurse P. 9/12/18 at 11:09 p.m. Resident returned to facility and adjusting well. Signed licensed nurse R. 9/12/18 CT scan of right hip final report findings: There is a right greater trochanteric fracture which is mildly displaced. The is no additional acute fractures noted. 9/13/18 at 12:50 p.m. Staff went in and checked	S3156		

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S3156	Continued From page 38 on resident. Resident was sitting in recliner and was incontinent of urine. Three staff helped resident up and to the restroom. Staff encouraged resident to use call light when needing any help. Signed licensed nurse O. 9/13/18 at 9:26 p.m. Resident using call pendant for assistance and required two staff assist with transfers. Signed licensed nurse Q. Documentation through September 2018 continued to identify that two staff were required to assist with transfers. 10/12/18 at 6:25 a.m. This nurse assisted resident with shower and asked if resident if needed assistance with dressing and resident stated, "If I need help, (resident #635 family member) can help me." Signed licensed nurse R. Interview at 3:45 p.m. on 10/16/18 with resident #633 stated fell and broke right hip. Resident stated does get up by self without help, then stated no weight bearing on right leg due to broken hip and right foot hurts too. Resident further stated, dressed self, and transfers self to wheelchair. Resident #635 (family member) stated he/she dressed, toileted, transferred resident #633 because he/she could not dress self, transfer self or stand on right leg. The only help resident #635 (family member) did not provide was a shower because he/she felt like he/she was not comfortable to do that and may drop him/her. Resident #635 will call for help if resident #633 needed assistance.	S3156		

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S3156	Continued From page 39 Interview at 4:05 p.m. on 10/16/18 with certified staff B stated resident used to be independent until last fall with broken hip and now required physical assistance with all ADL ' s and is dependent on staff for transfers. Interview at 4:15 p.m. on 10/16/18 with licensed nurse P state he/she was not aware that resident ' s (family member #635) was assisting resident #633 with transfer, dressing, and toileting. Interview on 10/16/18 at 4:30 p.m. with licensed nurse A stated and confirmed the NSA/HCSP did not reflect resident ' s needs for fractured hip. The NSA/HCSP lacked interventions for staff to provide care and services for fractured right hip and lacked a description of the health care services to be provided by resident #635 (family member) who stated transferred resident and provided care and services. For resident #633, the licensed nurse failed to provide and coordinate health care services to meet the residents.	S3156		
S3261 SS=E	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	S3261		

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S3261	Continued From page 40 This REQUIREMENT is not met as evidenced by: 26-41-105 (f) (11) The facility identified a census of 58 residents. The sample included 3 residents and 1 closed record review. Based on record review, interview and observation, for 2 of 3 sampled residents (#644 and #633) the administrator failed to ensure the record contained documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of action - Record review for resident #644 recorded an admit date of 8/19/16 with diagnoses of hypertension, depression, and arteriosclerotic heart disease. The annual functional capacity screen (FCS) dated 8/1/17 recorded resident independent with toileting, transfer, walking/mobility, eating, required supervision with bathing, dressing, bladder incontinence, physical assistance for management of medications/treatments, experienced short-term memory loss, memory recall, impaired vision, and impaired hearing. The resident did not experience falls/unsteadiness. The annual negotiated service agreement (NSA)/health care service plan (HCSP) dated	S3261		

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(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
S3261	Continued From page 41 8/1/17 recorded resident independent with toileting, transfers, walking/mobility, eating, required supervision with bathing, dressing, physical assistance with management of medications/treatments, incontinent care, experienced short-term memory loss, memory recall, impaired vision wears glasses, hard of hearing and wears hearing aide in left ear. Mobility devices: Walker, Mechanical lift chair. The significant change FCS dated 1/29/18 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walking/mobility, management of medications/treatments, incontinent of bladder control, experienced short-term memory loss, memory recall, decision-making, experienced impaired vision, impaired hearing, and falls/unsteadiness. The significant change NSA/HCSP dated 3/1/18 recorded resident required physical assistance of one to two staff for bathing, dressing, and toileting. Transfers required physical assistance of two staff, gait belt, and us of electric lift chair. For walking/mobility required physical assistance of one staff to propel in wheelchair. Resident independent with eating. Facility staff to administer medications and manage wound care. Resident frequently incontinent and require assistance with dressing, perineal care, and assistance with transfer. Resident occasionally incontinent of bowels and require assistance with perineal care, assist with changing clothes and transfer. Resident has short-term memory loss, poor memory recall, and decision making. Resident has falls/unsteadiness, poor eye sight, and hard of hearing. May use wheelchair or	S3261		

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	N087082	A. BUILDING: _____ B. WING _____	10/29/2018

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S3261	Continued From page 42 mechanical lift or recliner. The progress notes recorded the following: 1/7/18 at 4:30 a.m. Resident called staff to room when staff arrived resident was laying on left hip on floor next to bed. When staff asked what happened resident stated was sitting on side of bed when slid off. Resident put back to bed and reminded to call when needed help. Signed licensed nurse Q. The record lacked documentation of an assessment by the nurse at the time of the incident. 1/7/18 at 3:51 p.m. Resident complained of right hip pain when attempting to sit early this morning. Resident wincing in pain. The nurse spoke with family and order was obtained to get an x-ray. X-ray obtained and resulted with slight valgur angulation potentially due to fracture, but x-ray read if continued pain considers CT-scan or MRI. Resident assisted to bathroom and assisted to get dressed this morning. No complaint of pain at this time. Signed licensed nurse R. The documentation lacked the time the medical care provider was notified, time the xray was obtained and follow up. 1/8/18 at 5:44 p.m. Resident found by housekeeping around 9:50 a.m. nearly falling off bed. This nurse and staff went into room.	S3261		

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S3261	Continued From page 43 Resident leaning to left side and unable to sit up without assistance. Blood Pressure (B/P) 99/56, Pulse (P) 95, Temperature (T) 97.3. When staff attempted to stand resident, he/she continued to lean to left side. EMS notified. Resident wincing upon sitting when fire department attempted to stand resident. EMS transferred resident to hospital. Signed licensed nurse R. 2/2/18 at 10:45 a.m. resident returned to facility and family present. A home health aide arrived and assisted resident to dining room. Signed licensed nurse O. The record lacked an assessment of the resident upon return to the facility and explanation of absence from the facility 2/7/18 at 11:33 a.m. Sitter alerted this nurse regarding a sore to resident ' s right heel. Resident has a pressure sore measuring 6 centimeters (CM) by 7 CM and pitting edema to both feet. This nurse call physician and left message to return call. Signed licensed nurse G. The documentation lacked a description of the wound and surrounding tissue. 2/7/18 at 6:09 p.m. received orders to restart Lasix 40 milligrams (MG) for edema. Apply betadine four times a day to pressure ulcer on right heel. Resident allergic to iodine awaiting new orders. Signed licensed nurse M	S3261		

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S3261	Continued From page 44 2/10/18 at 4:19 p.m. Received orders for resident to have wound care consulted. Will follow up on Monday. Orders for duoderm to be applied daily. Signed licensed nurse R. The Medication Administration Record (MAR) lacked documentation of duoderm applied to heel until 2/12/18 and the record lacked a description of the treatment provided and an ongoing assessment of the wound. 2/24/18 at 3:12 p.m. Right heel dressing changed per order and appears to be healing well. No complaints of discomfort or redness. Signe licensed nurse R. The documentation lacked a description of the wound. 5/9/18 at 11:38 p.m. Staff responded to resident call pendant and found resident on the floor sitting with legs straight out in front of him/her in front of night stand. Resident stated slid out of bed and caught arm but does not have any pain. Signed licensed nurse Q. The documentation lacked document of an assessment of the resident. 6/21/18 at 9:51 a.m. This nurse noticed resident had a sore on right heel. Physician notified. Signed licensed nurse T.	S3261		

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S3261	Continued From page 45 The documentation lacked a description of the wound. 6/30/18 at 2:18 p.m. Right heel cleansed with normal saline and applied skin prep to site. Site appears to be healing well and is mostly scabbed over. Signed licensed nurse R. The documentation lacked a description of the wound. 9/5/18 at 12:53 a.m. Resident call using pendant at 12:10 a.m. Resident was found on floor lying next to cabinet on left side. Walker in place. Noted blood to left elbow. No other injuries noted and no complaint of pain. Signed licensed nurse P. The documentation lacked a description of the injury that resulted in bleeding and follow up 9/18/18 at 9:40 a.m. This nurse left a message with physician about getting a hip x-ray due to resident not wanting to stand and walk on it. Signed licensed nurse O. The record lacked a description of an assessment of the resident and follow up actions. Interview on 10/17/18 at 1:05 p.m. with licensed nurse O stated resident #644 returned from rehab due to fall with fractured hip and had to have a sitter twenty-four hours a day seven days a week.	S3261		

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S3261	Continued From page 46 Resident is a two-person transfer. Interview on 10/17/18 at 1:40 p.m. with resident stated he/she ambulated by self, dresses self, goes to restroom by self and did not need assistance. Observed a gait belt around his/her waist and asked what that was for and he/she stated did not know what it was. Resident was sitting in chair. Surveyor asked if he/she ate lunch and he/she stated no and was hungry. Interview on 10/17/18 at 1:45 p.m. with certified staff L state resident at lunch in dining room and had just got back to room. Resident is unable to get up by self and will call using the call pendant if wants to get up. Resident required two staff assist for transfer and ambulation. Is not using hoyer lift at this time but after he/she returned from rehab was using the hoyer lift. For resident #644, the administrator failed to ensure the record contained documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of action. - Record review for resident #633 revealed an admit date of 2/28/14 with diagnoses of arthritis, seizures, atrial fibrillation, hypertension, and spinal stenosis. The annual functional capacity screen dated (FCS) 2/27/18 recorded resident independent with eating, required supervision with bathing, dressing, toileting, transfer, walking/mobility,	S3261		

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S3261	Continued From page 47 management of medications/treatments, bladder incontinence, experienced short-term memory loss, memory/recall, impaired vision, hard of hearing, and falls/unsteadiness. The negotiated service agreement (NSA)/health care service plan (HCSP) dated 2/27/18 recorded resident required supervision by nursing staff and spouse for bathing dressing, toileting, transfers, walking/mobility, management of medications/treatments. Resident is incontinent of bladder and independent in care. For cognition has short-term memory loss and memory recall. Problems and risks resident has had are falls/unsteadiness, wears glasses for poor eye sight, has bilateral hearing aids but does not wear. Mobility devices used are a walker. Fall intervention care plan: re-orient to use call pendent and remove plastic chairs in room. The resident progress notes recorded the following: 9/10/18 at 9:06 a.m. Resident #635 (family member) used call pendent around 8:40 a.m. to alert staff of resident #633 falling. Resident #633 stated was sitting at the kitchen table in a plastic chair and tried scooting the chair out and fell over. Resident stated he/she hit head on the floor and landed on right leg/hip area. Staff went to help resident up to feet and was very weak and could not walk. Staff got a wheelchair and assisted resident to recliner. Blood Pressure (B/P) 157/75, Pulse (P) 75, Temperature (T) 97.5. This nurse called physician and got a STAT order	S3261		

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S3261	Continued From page 48 for an x-ray for right femur. Signed licensed nurse O. The record lacked documentation of an assessment by the nurse at the time of the fall, lacked documentation of the time the x-ray was performed and lacked follow up for the xray results until asked by the spouse around 4 p.m. 9/10/18 at 5:34 p.m. This nurse wet in to get vital signs about 4:00 p.m. Resident was changing own pants in recliner and I observed a gash on right knee. Resident said it was from the fall this morning. I also noticed bruising in the elbow are on right arm. Resident stated it was from fall this morning as well. Steri strips applied and covered with telfa. Resident #635 (family member) asked about x-ray results. This nurse called the doctor and was informed would return call. At 4:40 p.m. doctor called this nurse and instructed to send resident to hospital because resident had a fracture and would have a bed waiting for resident at hospital. Emergency Medical Services (EMS) notified and this nurse helped resident pack. Resident #635 (family member) decided to stay at facility and would notify family. Resident left by EMS around 5:00 p.m. Signed licensed nurse P. 9/12/18 at 11:09 p.m. Resident returned to facility and adjusting well. Signed licensed nurse R. 9/12/18 CT scan of right hip final report findings: There is a right greater trochanteric fracture which is mildly displaced. The is no additional acute fractures noted.	S3261		

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S3261	Continued From page 49 The record lacked documentation of an assessment of the resident upon return to the facility and lacked follow up assessments related to the fractured hip. Interview at 3:45 p.m. on 10/16/18 with resident #633 stated fell and broke right hip. Resident stated does get up by self without help, then stated no weight bearing on right leg due to broken hip and right foot hurts too. Interview at 4:05 p.m. on 10/16/18 with certified staff B stated resident used to be independent until last fall with broken hip and now required physical assistance with all ADL ' s and is dependent on staff for transfers. For resident #633, the administrator failed to ensure the record contained documentation of all incidents, symptoms and other indications of illness or injury.	S3261		
S3265 SS=F	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S3265		

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S3265	Continued From page 50 This REQUIREMENT is not met as evidenced by: KAR 26-42-104(a) The facility identified a census of 58 residents. The sample included 3 residents and 1 closed record review. Based on record review and interviews for all residents, the administrator failed to ensure the provision of a sufficient number of staff members to take resident who would require assistance in an emergency or disaster to a secure location when he/she failed to document the ability to safely evacuated residents with the least number of staff on duty. Findings included: - Resident roster provided on 10/15/18 at 11:15 a.m. identified 12 residents required transfer assistance to toilet and 6 residents identified with impaired cognition. Interview on 10/16/18 at 1:00 p.m. with licensed nurse G stated had two residents who required two staff assist for transfer and identified resident's #644 and #633. On 10/17/18 at 12:40 p.m. administrator provided two annual fire drill reports conducted on 12/6/17 at 1:42 a.m. with 5 staff participating (no time recorded). Second annual fire drill conducted on 5/4/18 at 6:04 a.m. with 4 staff participating took 7 minutes. Interview with licensed nurse A stated on night shift 10:00 p.m. to 6:00 a.m. had two staff on duty. Interview on 10:17 at 1:45 p.m. with certified staff L stated resident #644 and #633 required two	S3265		

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S3265	Continued From page 51 person assist for transfer. Interview on 10/17/18 at 12:20 p.m. with administrator stated had not conducted an evacuation with only two staff members participating. For all residents, the administrator failed to ensure the provision of a sufficient number of staff members to take resident who would require assistance in an emergency or disaster to a secure location when he/she failed to document the ability to safely evacuated residents with the least number of staff on duty.	S3265		