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 _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES SENIOR LIVING COMMUNITY	1400 S 183RD W 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 an abbreviated survey with investigation of complaint #92485 of the above assisted living facility on 11/10/15, 11/12/15, 11/17/15, and 11/18/15.	S 000		
S 125 SS=D	26-39-103 (f) Resident Right Free Choice (f) Free choice. The administrator or operator shall ensure that each resident, or resident ' s legal representative on behalf of the resident, is afforded the right to perform the following: (1) Choose a personal attending physician; (2) participate in the development of an individual care plan or negotiated service agreement; (3) refuse treatment; (4) refuse to participate in experimental research; and (5) choose the pharmacy where prescribed medications are purchased. If the adult care home uses a unit-dose or similar medication distribution system, the resident shall have the right to choose among pharmacies that offer or are willing to offer the same or a compatible system. This STANDARD is not met as evidenced by: KAR 26-39-103(f)(3) The facility reported a census of 65 residents. The sample included 2 residents and 5 closed records reviewed. Based on record review and interview for 1 (#6) of 5 closed records reviewed, the administrator failed to ensure the resident was afforded the right to refuse treatment. Findings included:	S 125		

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

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S 125	Continued From page 1 - Closed record review for resident #6 revealed an admission date of 8/27/15 and diagnoses of ulcerative colitis and Crohn's disease. The functional capacity screen dated 8/26/15 indicated the resident required supervision with transferring and mobility, required physical assistance with bathing, dressing, toileting, eating, and management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls, experienced impaired vision; and wore a sling to right arm at all times; required administration of folic acid (supplement), magnesium oxide (supplement), and ibuprofen (pain relief); had a colostomy and a feeding tube; and was to receive physical, occupational, and speech therapy. The functional capacity screen lacked documentation if resident or another person was responsible for the resident's legal and financial matters. The director of nursing signed the functional capacity screen on 8/26/15. The negotiated service agreement for resident #6 lacked a health care service plan to describe the health care services to be provided and the provider of the services. Review of resident progress notes revealed documentation by licensed nurses that resident received service of medication administration, tube feedings, wound care at ostomy site, and ostomy care. The progress notes contained an entry by the director of nursing on 9/3/15 at 9:09 a.m. that he/she was notified by nursing staff at approximately 10:00 p.m. on 9/2/15 of the	S 125		

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S 125	Continued From page 2	S 125		

resident's complaint of ostomy appliance leaking again and that resident was assisted by nursing staff in attempt to apply dressing/appliance as resident directed. "Due to frequent ostomy changes that have been required due to resident's continued scratching/picking at ostomy site with refusal of anti-itch medication. This (director of nursing) contacted (physician's name) the attending physician for the resident regarding our concern of resident's safety and well-being. Physician approved (director of nursing) to coordinate transfer to hospital for psych (psychiatric) evaluation and treatment of wound/ostomy." Director of nursing documented that he/she contacted the hospital emergency department and senior behavioral unit to confirm actions needed to have resident evaluated and admitted. Director of nursing documented that he/she arrived at the facility at 11:00 p.m. on 9/2/15 to find resident asleep in bed and ostomy appliance visibly leaking on abdomen and bed linens with severe redness/excoriation around stoma site. Director of nursing woke the resident to inform of need to transfer to hospital for evaluation. "(Resident) immediately became agitated/combative and demanding not to go." Resident stated "I just got to sleep and this can be handled in the morning." Director of nursing documented resident paid no regard to the fact that ostomy appliance was leaking and refused to allow facility nursing staff to change appliance as directed by wound/ostomy clinic. Spouse encouraged resident to go to hospital. Resident refused to be transferred by ambulance. Resident was assisted with dressing and transfer to the wheelchair in efforts to transfer to the hospital. Resident was transported to the hospital emergency department in the facility vehicle, accompanied by spouse, director of nursing, and residence director. The medical

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care provider evaluating the resident admitted the resident to the senior behavioral unit.

During an interview at 1:35 p.m. on 11/10/15, resident #6 stated he/she and spouse had been living at home and (he/she) fell fracturing right shoulder. Resident stated he/she and spouse decided to move to the facility for resident to receive assistance with tube feedings and ostomy care while the shoulder fracture healed. Resident stated (he/she) had been living in the facility for 3 or 4 days and was sound asleep that night in (his/her) apartment when a man and a woman woke (resident) and the man stated "We are taking you to the hospital." Resident said (he/she) asked the man and woman if it could wait until morning and the man said "No." Resident stated (he/she) began kicking with feet and slapping with one arm to resist going to hospital. When asked why (resident) needed to go to the hospital, resident stated (resident) did not know until the next morning when a psychiatrist informed (resident) that (he/she) was in the psychiatric unit because of "anxiety and the itch." Resident stated he/she did not know that it was a psychiatric unit until the next morning.

During an interview at 11:35 a.m. on 11/12/15, the director of nursing stated the resident did not know of plan to send to hospital for evaluation until 11:00 p.m. on 9/2/15 just prior to transport. Director of nursing confirmed resident requested to wait and be transferred to hospital in the morning but told resident "Would recommend not waiting until morning because ostomy appliance was leaking and you have irritated skin." Director of nursing stated that they felt resident's safety was in jeopardy because of skin issues.

The administrator failed to ensure resident #6

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S 125	Continued From page 4 was afforded the right to refuse treatment.	S 125		
S 185 SS=D	26-39-102 (d) Admission, Transfer, Discharge (d) The administrator or operator of each adult care home shall ensure that each resident is permitted to remain in the adult care home and is not transferred or discharged from the adult care home unless one of the following conditions is met: (1) The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the current adult care home. (2) The safety of other individuals in the adult care home is endangered. (3) The health of other individuals in the adult care home is endangered. (4) The resident has failed, after reasonable and appropriate notice, to pay the rates and charges imposed by the adult care home. (5) The adult care home ceases to operate. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(d)(1) The facility reported a census of 65 residents. The sample included 2 residents and 5 closed records reviewed. Based on record review and interview for 1 (#6) of 5 closed records reviewed, the administrator failed to ensure the resident was permitted to remain in the facility and was not transferred and then discharged when the resident's care needs did not change from the time of admission to the facility. Findings included:	S 185		

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S 185	Continued From page 5 - Closed record review for resident #6 revealed an admission date of 8/27/15 and diagnoses of ulcerative colitis and Crohn's disease. The functional capacity screen dated 8/26/15 indicated the resident required supervision with transferring and mobility, required physical assistance with bathing, dressing, toileting, eating, and management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls, experienced impaired vision; and wore a sling to right arm at all times; required administration of folic acid (supplement), magnesium oxide (supplement), and ibuprofen (pain relief); had a colostomy and a feeding tube; and was to receive physical, occupational, and speech therapy. The functional capacity screen lacked documentation if resident or another person was responsible for the resident's legal and financial matters. The director of nursing signed the functional capacity screen on 8/26/15. The negotiated service agreement for resident #6 lacked a health care service plan to describe the health care services to be provided and the provider of the services. Review of resident progress notes revealed documentation by licensed nurses that resident received service of medication administration, tube feedings, wound care at ostomy site, and ostomy care. The record contained the following entries by licensed nurses in the progress notes: 8/27/15 at 4:14 p.m. by director of nursing that	S 185		

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resident was admitted to facility. Abdominal wound care and ostomy appliance change provided according to ostomy clinic instructions.

8/28/15 at 12:28 a.m. by licensed nurse #A that resident reported ostomy appliance leaking. Ostomy appliance changed and resident tolerating tube feedings every 4 hours.

8/28/15 at 4:46 a.m. by licensed nurse #D that resident stated he/she had not slept all night due to bed being uncomfortable. Tube feeding completed and ostomy bag emptied. Assisted resident to recliner in living room.

8/28/15 at 12:18 p.m. by director of nursing of appointment made with physician to evaluate feeding tube for further orders and instructions. Appointment scheduled and resident notified.

8/29/15 at 4:30 a.m. that resident rested in hospital bed throughout shift. Tolerated scheduled tube feedings well. Used call light for help in changing brief. Resident shared that he/she was having a hard time letting others take care of (resident).

8/29/15 at 3:14 p.m. by licensed nurse #B that resident received a shower. Ostomy bag leaking and appliance changed per resident's direction. Resident stated that he/she was having a hard time with all these changes and stated that he/she was used to taking care of self and "I don't feel like I thought this through...moving here."

8/29/15 at 3:19 p.m. by licensed nurse #C for evening shift 8/28/15 "Resident is alert. Angry. Observed sitting in chair. Hospital bed delivered. This (nurse) understood that hospital bed was to be set up in living room. Resident refused to do

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this. Staff moved the bed in the bedroom to the living room." Licensed nurse #C documented that resident screamed "oh, my back." when assisted to standing position.

8/29/15 at 3:40 p.m. by licensed nurse #C of orders clarified with physician to consult occupational, physical , and speech therapy and home health. Lidoderm 5% (topical anesthetic) apply to affected area as needed and leave in place for up to 12 hours. May take children's Motrin (ibuprofen) as needed for pain. Continue sling to upper extremity and may remove sling for activities of daily living and hygiene.

8/29/15 at 9:30 p.m. by licensed nurse #A that resident received ibuprofen for complaint of pain and had no further complaints.

8/30/15 at 7:21 a.m. by licensed nurse #F that resident rested in hospital bed throughout night. Resident pleasant with staff and called for assistance with emptying ostomy bag and changing brief.

8/30/15 at 7:49 p.m. by licensed nurse #A that ostomy appliance was leaking and appliance changed. Resident refused use of adhesive to appliance due to allergy.

9/2/15 at 12:02 a.m. by licensed nurse #C that nurse administered tube feeding at 8:15 p.m. and resident stated nurse was late with feeding causing (resident's) blood sugar to be low. Licensed nurse stated he/she would check resident's blood sugar. Resident refused to allow blood sugar check.

9/2/15 at 12:36 a.m. by licensed nurse #D that resident refused to take medication (liquid

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ibuprofen administered as requested by resident for pain relief) if he/she could not see the container the medication was taken from.

9/2/15 at 8:08 a.m. by licensed nurse #E that ostomy appliance leaking and resident anxious and upset about ostomy appliance. Reminded resident that home health does ostomy/wound care. Contacted home health nurse to provide care.

9/2/15 at 8:43 a.m. by licensed nurse #E that resident refused to receive tuberculosis skin testing.

9/2/15 at 11:30 a.m. by director of nursing that resident requested assistance due to leaking ostomy appliance. Home health nurse arrived to provide care. "At this time appliance was changed twice due to resident picking (at) dressing causing it to leak."

9/2/15 at 12:15 p.m. by licensed nurse #E that resident reported ostomy appliance leaking and home health nurse had changed pouch mid-morning. Right side of ostomy bag peeled open and tape folded over. Nurse changed ostomy appliance and applied tape as resident requested.

9/2/15 at 3:31 p.m. by licensed nurse #A that ostomy appliance leaking. "Resident refused to allow re-application of new appliance in compliance with wound care clinic and home health nurse recommendations." Licensed nurse #A documented notification of director of nursing.

9/2/15 at 3:40 p.m. by director of nursing that he/she gathered all supplies for resident from closet for resident to change the ostomy

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appliance as resident prefers. Skin surrounding area appears red and irritated. Resident cleaning skin around stoma with baby wipes. Resident had previously stated not to use baby wipes near the stoma due to skin irritation. Director of nursing reminded resident of this statement and resident denied making that statement. "Resident left with needed supplies to change ostomy appliance."

9/2/15 at 9:57 p.m. by licensed nurse #A that ostomy appliance leaking and resident refusing to allow nursing to apply ostomy appliance in accordance with orders from wound clinic. Resident refused use of baby wipes to ostomy site stating that it had to be soap and water. Area cleansed with normal saline. Resident insisted that gauze be placed on the appliance to prevent skin irritation. Provided resident with supplies to apply appliance. Resident stated that nurse would have to apply because resident's arm hurt and he/she was too weak. Nurse informed resident that he/she would apply the appliance in compliance with resident's orders but would not apply gauze to the site. Resident insisted on gauze. "This nurse observed application, which does not appear to be intact."

9/3/15 at 9:09 a.m. by director of nursing that he/she was notified by nursing staff at approximately 10:00 p.m. on 9/2/15 that resident complained of ostomy appliance leaking again and that resident was assisted by nursing staff in attempt to apply dressing/appliance as resident directed. "Due to frequent ostomy changes that have been required due to resident's continued scratching/picking at ostomy site with refusal of anti-itch medication. This (director of nursing) contacted (physician's name) the attending physician for the resident regarding our concern

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of resident's safety and well-being. Physician approved (director of nursing) to coordinate transfer to hospital for psych (psychiatric) evaluation and treatment of wound/ostomy." Director of nursing documented that he/she contacted the hospital emergency department and senior behavioral unit to confirm actions needed to have resident evaluated and admitted. Director of nursing documented that he/she arrived at the facility at 11:00 p.m. on 9/2/15 to find resident asleep in bed and ostomy appliance visibly leaking on abdomen and bed linens with severe redness/excoriation around stoma site. Director of nursing woke the resident to inform of need to transfer to hospital for evaluation. "(Resident) immediately became agitated/combative and demanding not to go." Resident stated "I just got to sleep and this can be handled in the morning." Director of nursing documented resident paid no regard to the fact that ostomy appliance was leaking and refused to allow facility nursing staff to change appliance as directed by wound/ostomy clinic. Spouse encouraged resident to go to hospital. Resident refused to be transferred by ambulance. Resident was assisted with dressing and transfer to the wheelchair in efforts to transfer to the hospital. Resident was transported to the hospital emergency department in the facility vehicle, accompanied by spouse, director of nursing, and residence director. The medical care provider evaluating the resident admitted the resident to the senior behavioral unit.

9/9/15 at 5:18 p.m. the director of nursing documented "This resident returned to (facility) from (senior behavioral unit) prior to authorization by this director of nursing due to increased complexity of care needs and resident's non-compliance with care directions while in the

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hospital. At time of assessment the a.m. this nurse encouraged SNU (skilled nursing unit) for further care and to expedite the resident's goal of returning home due to physician's recommendations for 24 hour nursing care. Resident returned to the facility accompanied by spouse at approximately 1315 (1:15 p.m. while this (nurse) was eating lunch. Resident was provided a 30 day involuntary notification by (residence director) and this nurse at approximately 1400 (2:00 p.m.). At that time options for further care were discussed with resident and spouse." The director of nursing documented resident agreed to a stay at skilled rehabilitation facility and arrangements were made at that facility for the resident to be admitted there. Resident and spouse left the facility at 5:10 p.m.

During an interview at 1:35 p.m. on 11/10/15, resident #6 stated he/she and spouse had been living at home and (he/she) fell fracturing right shoulder. Resident stated he/she and spouse decided to move to the facility for resident to receive assistance with tube feedings and ostomy care while the shoulder fracture healed. Resident stated (he/she) had been living in the facility for 3 or 4 days and was sound asleep that night in (his/her) apartment when a man and a woman woke (resident) and the man stated "We are taking you to the hospital." Resident said (he/she) asked the man and woman if it could wait until morning and the man said "No." Resident stated (he/she) began kicking with feet and slapping with one arm to resist going to hospital. When asked why (resident) needed to go to the hospital, resident stated (resident) did not know until the next morning when a psychiatrist informed (resident) that (he/she) was

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in the psychiatric unit because of "anxiety and the itch." Resident stated he/she did not know that it was a psychiatric unit until the next morning. Resident stated he/she remained in the hospital for 6 days. Resident stated he/she did not receive any psychiatric treatment while in the hospital but did receive daily ostomy and skin care from the wound/ostomy clinic nurses. Resident stated the facility director of nursing and a man came to see resident on the day the resident was to be dismissed from the hospital. Resident stated the director of nursing told the hospital physician he/she did not want resident to return to the facility. After the hospital physician, the facility director of nursing, and the man from the facility left, three nurses came in and packed up the resident's belongings and told the resident's spouse to go get the car since the resident had been dismissed from the hospital. Resident said we went back to facility to get our belongings and we were going to go back home. A man came in and gave us a paper that we were being involuntarily released because I would not follow doctor's orders. Resident stated they went home and then he/she was admitted to a skilled facility for rehabilitation.

At 10:40 a.m. on 11/12/15, the residence director stated the resident was transferred from the facility on 9/2/15 to the hospital for a psychiatric evaluation due to resident being "manic and pulling on pouch." Residence director stated the director of nursing received a call that resident was to be dismissed from the hospital and director of nursing went to hospital to assess the resident. Residence director stated the director of nursing was informed by the hospital physician that the resident would be going to a rehabilitation facility and not returning to the assisted living facility. Residence director stated the resident

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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
S 185	Continued From page 13	S 185		

and the spouse returned to the facility and he/she gave the resident a 30 day involuntary discharge notice. Residence director provided a written statement that at 2:00 p.m. on 9/9/15 (he/she) was informed the resident returned to the facility and resident had informed nurses that (resident) was not going to follow medications and wound care orders. The management team decided to issue the resident a 30-day notice of involuntary discharge from the facility for endangering self. Director of nursing arranged for resident to go to a skilled facility for rehabilitation.

During an interview at 11:35 a.m. on 11/12/15, the director of nursing stated the resident did not know of plan to send to hospital for evaluation until 11:00 p.m. on 9/2/15 just prior to transport. Director of nursing confirmed resident requested to wait and be transferred to hospital in the morning but told resident "Would recommend not waiting until morning because ostomy appliance was leaking and you have irritated skin." Director of nursing stated that they felt resident's safety was in jeopardy because of skin issues.

At 3:10 p.m. on 11/12/15, received a written statement from director of nursing that documented he/she had visited resident in the hospital on 9/9/15 to observe the wound/ostomy nurse provide care in order to ensure dressing changes were completed as they were in the hospital. Director of nursing documented resident informed (him/her) and hospital physician that resident was not returning to the facility. Resident returned to facility at 1:15 p.m. that day accompanied by spouse. Resident refused to let director of nursing see hospital discharge papers. Resident stated spouse would be providing ostomy care. Director of nursing informed the residence director and it was

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	N087082	A. BUILDING: _____ B. WING _____	11/18/2015

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S 185	Continued From page 14 decided to issue the resident a 30-day involuntary discharge notice. Review of the involuntary discharge letter provided to the resident and dated 9/9/15 documented discharge date "on 10/8/15 or before because your care needs exceed manageability. You have failed to comply with physician orders regarding tube feedings, wound care treatment, and colostomy changes, which place you in danger to yourself." At 3:50 p.m. on 11/12/15, the senior behavioral unit clinical care coordinator stated the resident was admitted to the psychiatric unit due to facility's report that resident was combative and argumentative with facility staff. Clinical care coordinator stated documentation by the emergency department medical care provider revealed a medical evaluation due to picking at ostomy site, refusing medications, and refusing to eat as reported by the facility. Clinical care coordinator stated the inter-agency transfer form contained documentation of diagnoses of mood disorder, rule out obsessive/compulsive disorder, ulcerative colitis, and arthritis. Resident was dismissed with an order for haldol (antipsychotic medication) 0.5 milligram every 4 hours as needed for agitation and lorazepam (anti-anxiety medication) 0.5 milligrams every 4 hours as needed for anxiety. The administrator failed to ensure resident #6 was permitted to remain in the facility and was not transferred and then discharged when the resident's care needs did not change from the time of admission to the facility.	S 185		

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S3080	Continued From page 15	S3080		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 65 residents. The sample included 2 residents and 5 closed records reviewed. Based on record review and interview for 1 (#4) of 5 closed records reviewed and 2 residents reviewed, the director of nursing failed to conduct a screening (on the screening form specified by the department) on or before the resident's admission to the facility in order to determine the resident's functional capacity. Findings included: - Closed record review for resident #4 revealed an admission date of 8/27/15. The record lacked a functional capacity screen.	S3080		

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S3080	Continued From page 16 At 11:20 a.m. on 11/12/15, director of nursing provided a functional capacity screening form that documented the resident's first name; diagnoses of Alzheimer's disease, history of falls, and long term use of insulin; resident used a cane as a mobility device; resident administered levothyroxine (thyroid hormone), Novolog insulin, Novolin N insulin, ferrous sulfate (iron supplement), and Centrum Silver (vitamin), and that resident required monitoring of blood sugar. The screening form lacked documentation of the resident's ability to complete activities of daily living (ADL) and instrumental activities of daily living (IADL); the resident's ability to maintain urinary continence; cognitive status; ability to communicate and understand communication; any current or recent problems and risks; rehabilitation potential related to ADL/IADL; and the primary person for legal and financial matters. Director of nursing confirmed he/she did not conduct and complete the functional capacity screen on or before the resident's admission to the facility. The director of nursing failed to conduct a screening (on the screening form specified by the department) on or before the resident #4's admission to the facility in order to determine the resident's functional capacity.	S3080		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal	S3085		

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S3085	Continued From page 17 representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The facility reported a census of 65. The sample included 2 residents and 5 closed records reviewed. Based on record review and interview for 2 (#6 and #4) of 5 closed records reviewed and 2 residents sampled, the administrator failed to ensure the development of a written negotiated service agreement for each resident, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or if agreed to by the resident, the resident's family. Findings included: - Closed record review for resident #6 revealed an admission date of 8/27/15 and diagnoses of ulcerative colitis and Crohn's disease. The functional capacity screen dated 8/26/15 indicated the resident required supervision with transferring and mobility, required physical assistance with bathing, dressing, toileting,	S3085		

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S3085	Continued From page 18	S3085		

eating, and management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls, experienced impaired vision; and wore a sling to right arm at all times; required administration of folic acid (supplement), magnesium oxide (supplement), and ibuprofen (pain relief); had a colostomy and a feeding tube; and was to receive physical, occupational, and speech therapy. The functional capacity screen lacked documentation if resident or another person was responsible for the resident's legal and financial matters. The director of nursing signed the functional capacity screen on 8/26/15.

The negotiated service agreement for resident #6 documented general terms and conditions, the facility's obligation for general care of the resident, obligations of the resident, resident rights, conditions requiring dismissal, discharge, or transfer of resident, bed hold policy, and due dates of payment/refund policy. The negotiated service agreement contained the signature of the director of nursing on 8/26/15 and the residence director on 8/26/15. The negotiated service agreement lacked the signature of the resident to indicate the resident collaborated in the development of the negotiated service agreement.

At 3:00 p.m. on 11/10/15, the residence director stated the resident refused to sign the negotiated service agreement.

The administrator failed to ensure the development of a written negotiated service agreement for resident #6, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the

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S3085	Continued From page 19 resident. - Closed record review for resident #4 revealed an admission date of 8/27/15. The record lacked a functional capacity screen. At 11:20 a.m. on 11/12/15, director of nursing confirmed he/she did not complete a functional capacity screen for the resident. Director of nursing provided a functional capacity screening form that documented the resident's first name; diagnoses of Alzheimer's disease, history of falls, and long term use of insulin; resident used a cane as a mobility device; resident administered levothyroxine (thyroid hormone), Novolog insulin, Novolin N insulin, ferrous sulfate (iron supplement), and Centrum Silver (vitamin), and that resident required monitoring of blood sugar. The screening form lacked documentation of the resident's ability to complete activities of daily living (ADL) and instrumental activities of daily living (IADL); the resident's ability to maintain urinary continence; cognitive status; ability to communicate and understand communication; any current or recent problems and risks; rehabilitation potential related to ADL/IADL; and the primary person for legal and financial matters. The negotiated service agreement for resident #4 documented general terms and conditions, the facility's obligation for general care of the resident, obligations of the resident, resident rights, conditions requiring dismissal, discharge, or transfer of resident, bed hold policy, and due dates of payment/refund policy. The negotiated service agreement contained the signature of the residence director without a signature date. The negotiated service agreement lacked the signature of the resident or resident's family	S3085		

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S3085	Continued From page 20 member to indicate the resident collaborated in the development of the negotiated service agreement. During an interview at 11:20 a.m. on 11/12/15, director of nursing stated resident and resident's family member refused to sign the negotiated service agreement. The administrator failed to ensure the development of a written negotiated service agreement for resident #4, based on the resident's service needs, and preferences, in collaboration with the resident.	S3085		
S3156 SS=D	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(b) The facility reported a census of 65. The sample included 2 residents and 5 closed records reviewed. Based on record review and interview for 2 (#6 and #4) of 5 closed records reviewed and 2 residents sampled, the administrator failed to ensure the director of nursing developed a	S3156		

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S3156	Continued From page 21 health care service plan in collaboration with the resident for residents #6 and #4 who required health care services. Findings included: - Closed record review for resident #6 revealed an admission date of 8/27/15 and diagnoses of ulcerative colitis and Crohn's disease. The functional capacity screen dated 8/26/15 indicated the resident required supervision with transferring and mobility, required physical assistance with bathing, dressing, toileting, eating, and management of medications and treatments; was frequently incontinent of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls, experienced impaired vision; and wore a sling to right arm at all times; required administration of folic acid (supplement), magnesium oxide (supplement), and ibuprofen (pain relief); had a colostomy and a feeding tube; and was to receive physical, occupational, and speech therapy. The functional capacity screen lacked documentation if resident or another person was responsible for the resident's legal and financial matters. The director of nursing signed the functional capacity screen on 8/26/15. The negotiated service agreement for resident #6 lacked a health care service plan to describe the health care services to be provided and the provider of the services. Review of resident progress notes revealed documentation by licensed nurses that resident received service of medication administration, tube feedings, wound care at ostomy site, and ostomy care.	S3156		

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S3156	Continued From page 22 During an interview at 11:35 a.m. on 11/12/15, the director of nursing stated he/she did not complete a health care service plan in collaboration with the resident. Director of nursing stated staff provided ostomy care, wound care, and tube feedings to the resident based on documentation provided by a wound/ostomy clinic and director of nursing's observations of care provided to the resident by a home health care nurse in the resident's home. Director of nursing stated he/she verbally shared these instructions for care with facility staff members. Director of nursing stated he/she could not say if resident agreed to the health care services. The administrator failed to ensure the director of nursing developed a health care service plan for resident #6 in collaboration with the resident who required health care services. - Closed record review for resident #4 revealed an admission date of 8/27/15. The record lacked a functional capacity screen. At 11:20 a.m. on 11/12/15, director of nursing confirmed he/she did not complete a functional capacity screen for the resident. Director of nursing provided a functional capacity screening form that documented the resident's first name; diagnoses of Alzheimer's disease, history of falls, and long term use of insulin; resident used a cane as a mobility device; resident administered levothyroxine (thyroid hormone), Novolog insulin, Novolin N insulin, ferrous sulfate (iron supplement), and Centrum Silver (vitamin), and that resident required monitoring of blood sugar. The screening form lacked documentation of the resident's ability to complete activities of daily	S3156		

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S3156	Continued From page 23 living (ADL) and instrumental activities of daily living (IADL); the resident's ability to maintain urinary continence; cognitive status; ability to communicate and understand communication; any current or recent problems and risks; rehabilitation potential related to ADL/IADL; and the primary person for legal and financial matters. The negotiated service agreement for resident #4 lacked a health care service plan to describe the health care services to be provided and the provider of the services. Review of resident's medication administration record dated from 8/27/15 through 9/9/15 indicated the resident received health care service of facility management and administration of medications. Licensed nurses documented administration of insulin injections and monitoring of resident's blood sugar level and licensed nurses and certified medication aides documented administration of oral medications to the resident. At 11:20 a.m. on 11/12/15, director of nursing stated he/she did not develop a health care service plan for resident #4. The administrator failed to ensure the director of nursing developed a health care service plan for resident #6 in collaboration with the resident who required health care services.	S3156		