STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K 000}	Initial Comments The following citations represent the findings of a revisit (425795), and a visit for complaint investigations (425857) regarding complaints KS 26441 and KS 26596, conducted at the above named assisted living facility on 2/29/08, 3/04/08, 3/05/08, 3/06/08 and 3/07/08.	{K 000}		
K3025 SS=H	28-39-240(f) Staff Treatment of Residents (f) Staff treatment of residents. Each facility shall develop and implement written policies and procedures that prohibit abuse, neglect, and exploitation of residents. Each facility shall meet the following requirements: (1) Not use verbal, mental, sexual or physical abuse, including corporal punishment and involuntary seclusion; (2) not employ any individual who has been identified on the state nurse aide registry as having abused, neglected, or exploited residents in an adult care home; (3) ensure that all allegations of abuse, neglect, or exploitation are investigated and reported immediately to the administrator or operator of the facility and to the department; (4) provide evidence that all alleged violations are thoroughly investigated and take measures to prevent further potential abuse, neglect, and exploitation while the investigation is in progress; (5) report the results of all facility investigations to the administrator, operator, or designated representative; (6) maintain a written record of all	K3025		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 1 investigations of reported abuse, neglect, and exploitation; and (7) take appropriate corrective action if the alleged violation is verified. This RULE: is not met as evidenced by: KAR 28-39-240(f) Facility census equaled 40 residents with 6 residents reviewed. Based on observations, interviews and record reviews, for 3 of 6 residents reviewed (#1010, #1011, and #1007), the facility failed to implement written policies and procedures that prohibited neglect of these residents by failing to provide health care services necessary to ensure the health and safety of these residents. Findings included: -Surveyor review of resident #1010's clinical record on 2/29/08 revealed: 1) Admission to the facility on 2/20/06 with diagnoses that included Dementia and Depression. 2) Resident Log (RL) notes by licensed nursing staff on 6/08/07, 7/07/07, 7/26/07 that documented the following behaviors exhibited by the resident: verbally abusive to staff and residents; urinating and defecating in public areas of the facility; naked from the waste down in public areas of the facility; refusing all medications and care from staff; and hitting other residents and staff. 3) A Physician's faxed order sheet dated 6/12/07: "Resident refuses all care and medications. We need prn (as needed) IM (intramuscular -	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 2	K3025		

injection) so resident will take his/her medications and so staff can give care". The faxed order form contained the physician's order for Geodon 20 mg (milligrams) IM every 12 hours prn agitation.
4) RL 6/13/07 that documented the nurse was unable to give the "shot" (Geodon) and suggested to family that the resident be transferred to a senior geriatric psych unit for medication stability.
5) RL 8/01/07 documented the resident's family agreed to take the resident to the senior diagnostic hospital on 8/06/07. RL on 8/13/07 documented the resident returned to the facility.
6) Discharge form dated 8/13/07 from the hospital included the discharge diagnosis of vascular dementia with behavioral disturbances with depression, and included a diet order for finger foods and vanilla boost (dietary supplement) bid (twice daily).
7) Physician's order fax form dated 8/16/07 that contained documented to physician by nurse that resident refused to drink vanilla boost and an order received to discontinue the boost.
8) RL 8/24/07 by the Executive Director (ED) documented the ED contacted the resident's family that the resident continued to refuse medications, soiled self and refused to let staff change soiled clothing. The ED suggested a referral to a provider of psychotherapy services.
9) A Psychotherapy progress report dated 11/02/07 that therapy with this resident discontinued as resident was not appropriate for psychotherapy services due to advanced and severe dementia.
10) RL 11/26/07 that the facility moved the resident to the dementia unit of the facility.
11) Record of a visit to the physician's office by the resident and two staff members on 11/29/07 that contained documentation by the physician: "(resident) combative and we did not feel...should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 3	K3025		

be restrained to do physical exam...caregivers with (resident) say he/she is acting as he/she usually does" The physician further documented "Dementia - aggressive behavior - has history of both visual and auditory hallucinations".

On 2/29/08 at 12:30 p.m., surveyor observed the following: resident #1010 sitting at dining room table in dementia unit with a plate of food in front of resident that included meat, mashed potatoes, vegetables - no finger foods observed; the resident's hair unkempt and uncombed; the resident kept his/her arms folded and made no attempts to eat or drink; the resident would occasionally yell out "go away" or "leave me alone". A certified nurse aide (CNA) reported that resident #1010 would not allow staff to feed him/her and resisted all other care that staff tried to provide including dressing, toileting and showers. The CNA stated "it is hard to keep (resident) clean because he/she is combative". The CNA stated that the resident "needs finger foods - he/she has not been eating well". The CNA confirmed that the facility dietary staff were not providing finger foods for the resident. A certified medication aide (CMA) also reported that the resident had been refusing most of his/her medications on a consistent basis "for a long time now".

Further review of the resident's record revealed:
1) MARS (medication administration records) from June 2007 to February 2008 that confirmed the resident frequently refused medications.
2) Weight record that documented the resident's weight in August 2007 as 120 pounds, September 2007 107 pounds, and a weight on February 25, 2008 of 88 pounds (a 32 pound weight loss from August 2007 to February 2008).
3) Dietary consultation report dated 12/18/07 by a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 4 licensed dietitian that documented "no weight losses via nursing" and contained the signature of the facility nurse/Health Care Coordinator (HCC). On 2/29/08 at 12:45 p.m. and 3:05 p.m., the HCC confirmed that resident #1010 was refusing to eat or drink boost (and other fluids) and confirmed the resident had suffered a significant weight loss since August of 2007. The HCC stated that he/she obtained another order for boost on 2/19/08 but the resident refused to drink it. The HCC further confirmed that the resident exhibited the following behaviors: screaming or yelling out frequently; yelling at other residents and staff; resisted all care attempts by staff; was combative with staff during care; and refused all oral medications on a consistent basis. The HCC confirmed that the resident was last seen/evaluated by a physician on 11/29/07. The HCC reported that the physician gave a telephone order to the HCC on 11/29/07 (after the office visit with the resident), that resident #1010 needed psychiatric treatment. The HCC stated "that did not happen", and confirmed that he/she failed to obtain a psychiatric evaluation or psychiatric treatment for the resident as ordered by the physician on 11/29/07. The HCC also confirmed that resident #1010 was not seen/evaluated by a physician after 11/29/07, and that the HCC had not notified the physician after 11/29/07 of the resident's significant weight loss (including continued refusals to eat), refusals to take medications, refusals of care, combativeness with care, and screaming and yelling at staff and other residents. The HCC admitted that he/she never attempted to administer the Geodon injection (for the resident's agitation and behaviors) after the first attempt in June 2007 "because (resident #1010) won't let me near him/her". The HCC also	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 5 admitted that "around December" staff reported a wound on resident #1010's coccyx - "about the size of a dime, open area". The HCC stated "I faxed a request to the physician for (outside agency) to do wound care, but never heard back (from physician) so I just took care of it myself with antibiotic ointment and a dressing - it healed in a few days". The HCC confirmed that he/she never actually spoke with the physician about the wound, and never obtained an order to treat the wound with the antibiotic ointment and dressing. The HCC told surveyor that the resident currently had no open wounds/pressure areas on the buttocks, coccyx area, or peri-area. The HCC admitted that he/she was not keeping track of the resident's food and fluid intake or urinary output - despite the fact of the significant weight loss and staff reports that the resident was consistently not eating or drinking very well. On 2/29/08 at 1:15 p.m., the surveyor asked the HCC to complete a skin assessment on resident #1010 to ensure the resident did not have any skin breakdown. The HCC and surveyor approached the resident who was sitting in the living room area of the dementia unit. The HCC attempted to explain to the resident that he/she needed to take the resident to the bathroom, to toilet the resident and check his/her skin. The resident screamed "no, you get away from me, no I won't do it". The resident swung her arms at the HCC and became very agitated. The surveyor asked the HCC to attempt to complete this assessment at another time to avoid a catastrophic reaction from the resident. Further interviews with staff on 2/29/08 confirmed that resident #1010 was rapidly losing weight, not eating or drinking fluids, refusing to take medications on a consistent basis, was	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 6	K3025		

combative and struggling with staff with all care attempts; was digging his/her fingernails into self and staff; was unsteady with walking and at risk for falls; was unable to use eating utensils and needed finger foods that were not being provided by the facility; needed orange juice on a consistent basis (due to resident would usually drink orange juice when offered); and that the resident had not urinated all day on either dayshift or evening shift on 2/29/08.

On 2/29/08 at 6:25 p.m., a Registered Nurse (RN) from a local outside agency arrived at the facility (per the ED's request) to assess resident #1010 for dehydration.

On 3/04/08, surveyor reviewed resident shift reports (completed by certified staff) that documented resident #1010 fell on 1/21/08, 1/25/08, 2/01/08, 2/14/08 and 2/18/08. The certified staff documented that the resident received lacerations to the head following the falls on 1/25/08 and 2/14/08. Further review of resident #1010's clinical record on 3/04/08 revealed the following:
1) Skin assessment by an LPN dated 3/03/08 that documented: old bruises to right hip, right arm, left buttocks, scratches due to (finger)nails on left arm, scratch behind left ear, scratch on left shin, and 2 centimeter length pressure sores on both buttocks.
2) Physician orders dated 3/30/08 for a psychiatric consult/evaluation and treatment; Geodon 20 mg IM every 8 hours until (resident) is established with another physician and psychiatrist; and orders for hospice care.
3) Admission to hospice care on 3/03/08 that included documentation by a hospice RN that "resident agitated, pale, refusing food, fluids, and meds today - history of falls". The hospice RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 7 further documented that resident "digs nails into self - reddened perirectal area with two open areas - probable UTI (urinary tract infection) - two 0.5 centimeter open areas to left and right of rectum - and significant weight loss". On 3/04/08 at 1:15 p.m., surveyor observed the following: resident #1010 sitting at dining room table with most of food offered to the resident thrown on the floor by the resident; the resident talking and yelling at unseen others (one time screaming to the wall behind him/her "I am going to kill you") - upsetting other residents (also with dementia) at the dining room table who yelled back at resident #1010; 2 certified staff removed resident #1010 from the dining room and walked the resident a few steps towards the resident's apartment in order to toilet the resident and to remove the resident from the dining room (due to resident #1010 upsetting other residents), the resident attempted to sit down on the floor while staff were walking the resident towards his/her apartment - the resident refused to go to apartment or to be toileted - screaming the whole time and digging his/her fingernails into the two staff's arms; the two staff had to drag the resident into the bathroom - remove the resident's pants and brief - then attempted to provide personal hygiene care due to the resident was incontinent of bowel; the resident continued to scream, scratch the two staff and kick at the staff; staff attempted to walk resident out of the bathroom after completing the toileting - resident continued to scream and continued combative with staff - staff had to drag the resident to a recliner chair in the resident's apartment; certified staff and surveyor noted that the resident had sustained a small skin tear to the right hand following the toileting.	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 8 Interviews with several staff on 3/04/08 revealed the following: resident #1010 continued to refuse most food and fluids; continued to refuse oral medications; was hallucinating and talking or yelling at unseen others; was upsetting other residents in the dementia unit due to the yelling and screaming; was combative with all care - including digging his/her fingernails into herself and staff during care; was especially combative with staff during toileting - screamed and fought the entire toileting process; was verbally abusive towards some residents; and that the Geodon given by the nurse on 3/03/08 and 3/04/08 was not working to help the resident's behaviors. Interviews with staff also confirmed that resident #1010 fell on 1/21/08, 1/25/08, 2/01/08, 2/14/08 and 2/18/08 as documented in shift reports, and had suffered another fall on 3/02/08 (when the resident was on 1:1 care with a staff person). The staff reported that due to the resident's unsteadiness, he/she continued to be at a high risk for falls. These interviews revealed that the resident sustained a laceration to the back of the head following the fall on 1/25/08, and a laceration behind the resident's left ear following the fall on 2/14/08. The certified staff reported to surveyor that following these two falls with head injuries (on 1/25/08 and 2/14/08), the staff immediately notified the HCC about the falls/injuries/lacerations, but the HCC refused to come to the facility to assess the resident's injuries and gave no instructions to the certified staff on what they should do about the lacerations/head injuries. Certified staff reported that they notified the resident's family after the fall on 2/14/08 because they felt the laceration needed stitches - and that a family member came to the facility but was unable to take the resident to the hospital because the resident was so combative. The certified staff reported that they	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 9	K3025		

called the HCC back on 2/14/08 to report this, and to again inform the HCC that they (the certified staff) felt the resident required stitches and treatment for the laceration. The certified staff stated that the HCC again refused to come to the facility and told the staff it was the family's decision and responsibility to obtain treatment for the resident. The certified staff confirmed that the resident received no treatment for the laceration/head injury following the fall on 2/14/08.

On 3/04/08 at 2:00 p.m. and 4:55 p.m., the ED reported that the psychiatric "assessment" (ordered by the physician on 3/03/08) would not be available until "sometime next week" and that after the assessment, it would be "4 to 5 weeks" before the resident was actually seen by a psychiatrist. The ED agreed that resident #1010 continued to exhibit psychotic behaviors, was hallucinating, continued combative with all care (was injuring self and others during care), continued to refuse most food and fluids, and continued to refuse medications.

On 3/04/08 at 6:00 p.m., the ED stated "I went back to look at (resident #1010) and I believe he/she is a danger to him/herself and other residents - I am going to contact the family to have (resident #1010) transferred to the hospital". On 3/04/08 at 7:30 p.m., resident #1010 was transported to a local hospital.

The facility failed to prevent neglect of resident #1010. The facility failed to provide the following care and services necessary for the resident's health and safety: notification of the resident's physician of ongoing behaviors that included refusals of care, combativeness with care, refusals of medications, verbal abuse of staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 10	K3025		

other residents, and psychotic behaviors of auditory and visual hallucinations; failure by the licensed nurse to follow a physician's order on 11/29/07 to obtain psychiatric treatment for the resident to deal with these behaviors; no current assessments of the resident's skin by a licensed nurse and no services implemented to prevent skin breakdown; failure to provide finger foods to the resident as ordered on 8/13/07; failure to notify the resident's physician or the consultant dietitian regarding the resident's continued refusals to eat or drink adequate amounts or the resident's significant weight loss; failure to implement services to address the resident's high risk for falls; no assessments by a licensed nurse following falls on 1/25/08 and 2/14/08 that resulted in lacerations to the resident's head; and failure by the licensed nurse to provide or obtain appropriate medical treatment for those lacerations. Resident #1010 suffered harm that included: injuries to self during care and treatment due to ongoing combativeness with care, psychotic behaviors (digging fingernails into self and hallucinations that caused the resident mental and emotional distress and suffering as evidenced by continued screaming and yelling at unseen others), two stage 2 pressure ulcers, continued falls with injuries with no treatment provided to two lacerations following falls on 1/25/08 and 2/14/08, and significant weight loss.

-On 3/05/08 at 7:05 a.m., surveyor heard a certified medication aide (CMA) shouting: "we have a mess, there is blood everywhere". The CMA reported to surveyor that resident #1011 had fallen in his/her room and was bleeding from the knuckles, elbow and spine area. The CMA and surveyor entered resident #1011's apartment and observed the resident standing in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 11 apartment with a certified nurse aide (CNA) in attendance. Surveyor observed the following: lacerations to two fingers of the resident's left hand, two large skin tears to the resident's left elbow, and an abrasion (approximately 4 inches long) noted on the resident's upper back along the spine area; the resident was alert but not oriented to time or place and unable to state what happened; blood noted in a large area of the shower floor, bathroom floor, blood smeared on toilet seat, walls of the bathroom, a wall in the living room, on the resident's pillow, and several spots of blood noted on the carpet from the resident's bed to the bathroom. The CMA reported he/she had called the nurse and the nurse was on his/her way to the facility. The CMA and CNA had stopped most of the bleeding with a large towel and pressure to the areas. The CMA stated "(resident #1011) is having more falls - we were told he/she could take care of himself, but lately he/she cannot take care of self and is a danger if left alone due to he/she will fall". The CMA reported that the resident was more confused lately and was unsteady and would forget to call for help before he/she would get up from the bed or chair, and also "always forgets to use his/her walker". The surveyor observed that the resident had no shoes on - only socks. The CMA stated "his/her feet are swollen now and his/her shoes don't fit well". The CMA further stated "there is not enough staff here to watch him all day or all night to make sure he/she doesn't fall". The surveyor noted a sign on the wall beside the resident's bed "to call a nurse - pull the string". The CMA stated "he/she never uses it (the call light string) - he/she is too confused and doesn't remember to call". Surveyor review of resident #1011's clinical record on 3/05/08 revealed:	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 12 1) Admission to the facility on 12/07/07 with diagnoses that included Alzheimer's type Dementia with Behavioral Disturbances, Weakness, Coronary Artery Disease and Neuropathy. 2) Resident Log (RL) notes dated 1/25/08 that documented a fall that resulted in a skin tear to the resident's right elbow. 3) RL 1/26/08 at 5:15 a.m. "This nurse was called because resident was anxious and was observed crawling on the floor. Resident obtained rug burns on all toes and both knees. Resident also had a skin tear on his/her right hand". 4) RL 1/27/08 that resident was admitted to a local hospital for confusion and returned to facility on 1/30/08. 5) Discharge summary from the local hospital dated 1/30/08 that included the following diagnoses: dementia with delirium, dehydration, and physical debility and gait instability. The hospital course included the resident was hydrated with intravenous fluids and remained disoriented to time and place. The physician documented that the resident's dementia had worsened in past week or two, was a great fall risk, at a high risk for having strokes and that it was very probable (based on CT scan of the head) that he/she could be having recurrent small strokes contributing to his/her mental decline. The physician further documented: "This patient, in my opinion is unable to return to assisted living at this time - I recommend (resident) go to a living situation where he/she has skilled nursing care. We are currently having discussions and making arrangements for the patient to return to (facility), but on the skilled nursing side so that he/she may receive the skilled nursing care that he/she needs at this time... and (resident) should be up with assistance and the use of a walker...". The discharge orders included "up with assistance	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 13 and walker, bedside commode with assistance, PT (physical therapy) evaluate and treat, and restorative nursing". 5) Resident Negotiated Service Agreement (NSA) dated 1/07/08 that listed the following health care services to address the resident's risk for falls: staff to report any instability to nurse; staff to provide verbal cueing to use walker; staff will visually attempt to check on resident every 30 minutes and remind resident to use walker at all times; staff will remind resident to use call light for assistance when needing to get up out of a chair or bed; staff will remove any environmental objects to reduce resident's potential for tripping or falling. On 3/05/08 at 9:00 a.m., the Executive Director (ED) reported that resident #1011 "had sitters for awhile when he/she came back from the hospital for about 2 or 3 weeks". Surveyor asked the ED if he/she was aware of the physician's documentation and orders on 1/30/08 that resident #1011 required skilled nursing care and was being returned to this facility "on the skilled nursing side" to receive skilled nursing care. The ED reported he/she was unaware of these orders and stated "the nurse handled all that communication with the hospital and all the nurse told me was that (resident #1011) would require a sitter when he/she returned from the hospital". The ED confirmed that the facility lacked "a skilled nursing side", confirmed that the facility did not provide "restorative nursing" as ordered on 1/30/08. The ED stated "(resident #1011) is receiving PT, and confirmed that the resident's record lacked evidence of PT visits/treatments. The ED stated "I'll get those faxed to us today". The ED also confirmed that the health care services for fall prevention listed on the resident's NSA dated 1/07/08 was not effective to prevent	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 14 falls due to the resident could not remember to use call light to call for assistance before transfers, resident could not remember to use his/her walker, and that the facility lacked adequate staff to check on the resident every 30 minutes, especially at night due to only 1 staff person worked on the assisted living side of the facility on night shift. The surveyor asked the ED what the facility's plan was to keep resident #1011 safe from further falls and injuries. The ED stated "we are currently transporting (resident #1011) to the hospital due to the nurse's assessment that the cut (laceration) to his/her finger was very deep and he/she is more disoriented than usual". On 3/05/08 at 9:40 a.m. a certified staff person reported that staff tried to keep an eye on (resident #1011) in order to prevent falls, but could not watch him/her all the time. The certified staff stated "I have never known (the resident) to use his/her call light - he/she gets up by self all the time". The certified staff reported "(resident #1011) gets up at night and gets dressed - he/she gets confused and comes out and wanders in the hall - he/she never uses his/her walker". The facility failed to prevent neglect of resident #1011. The ED of the facility admitted that the health care services implemented by the facility to address the resident's risk for falls were not effective. The ED further admitted that the facility failed communicate to the hospital physician on 1/30/08 that this facility lacked "a skilled nursing side" and was unable to provide skilled nursing services or restorative nursing. The facility failed to provide appropriate and effective health care services to address the resident's risk for falls. The resident remained at	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 15 risk for falls following discharge from the hospital on 1/30/08 due to the resident's impaired cognitive status, inability to remember to call staff for assistance, inability to remember to use the walker and continued unsteadiness. The resident suffered harm/injuries from another fall on 3/05/08 (lacerations and skin tears) and required a transfer to the hospital. -On 3/05/08 at 7:20 a.m., surveyor observed the following: resident #1007 sitting in a wheelchair in the resident's apartment; a certified nurse aide (CNA) combing the resident's hair; the resident noted frail, alert, but confused to time and place; surveyor noted the resident with contractures of both arms and fingers of both hands and that the resident leaned severely to the left side of the wheelchair. The CNA reported that resident #1007 required total assistance with all activities of daily living (bathing, dressing, transfers, mobility per wheelchair, and feeding the resident). The surveyor observed the CNA washing the resident's face and then push the resident's wheelchair to the dining room for breakfast. On 3/05/08 at 1:00 p.m., surveyor asked the ED if the licensed nurse had performed a recent skin assessment on resident #1007 to ensure the resident had no skin breakdown. The ED stated that the nurse could do the assessment now. At 1:15 p.m., surveyor made the following observations: a CNA transferred the resident from the wheelchair to a bed in the resident's apartment; an LPN and the CNA removed the resident's clothing; the LPN checked the resident's skin - no open areas noted on the resident's buttocks or periarea, back or arms; the surveyor then asked the LPN to check the skin of the resident's palms of both hands due to severe	K3025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3025	Continued From page 16 contractures of the resident's fingers; the LPN gently stretched the fingers of the right hand open and an immediate foul odor filled the room and the LPN and surveyor noted a sticky white substance covering the palm of the right hand - the LPN cleaned the resident's right hand; the LPN then stretched open the fingers of the resident's left hand and again a foul odor was noted with a black substance covering the inside of the resident's fingers and over the resident's palm area. The LPN stated "I think it is just old food and coffee - (resident #1007) tries to use this hand sometimes to feed self". The LPN and surveyor noted the resident's nails were long and the LPN confirmed that the fingernails needed trimmed. The LPN cleaned the resident's left hand and fingers. The foul odor remained in the room. The ED was also in attendance and stated "I would have never thought to clean under the resident's fingers" and confirmed that certified staff obviously did not know they were to clean the resident's hands or notify the nurse to assist them in cleaning the contractured hands/fingers. The facility failed to prevent neglect of resident #1007 based upon surveyor's observations, and based on confirmation by the facility ED that staff failed to provide appropriate care and hygiene of the resident's contractured hands and fingers.	K3025		
K3065 SS=G	28-39-242 Admission, Transfer, Discharge (a) Each assisted living or residential health care facility shall develop and implement written admission, transfer and discharge policies which protect the rights of residents as required by K.A.R. 28-39-148. In addition, the facility shall not admit or retain residents who have one or more of the following conditions unless the negotiated service agreement includes hospice or	K3065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3065	Continued From page 17 family support services which are available 24 hours a day or similar resources: (1) Incontinence, where the resident cannot or will not participate in management of the problem; (2) immobility, where the resident requires total assistance in exiting the building; (3) any ongoing condition requiring a two-person transfer; (4) any ongoing skilled nursing intervention needed 24 hours a day for an extended period of time; or (5) any behavioral symptom that exceeds manageability. This RULE: is not met as evidenced by: KAR 28-39-242(a)(1)(5) Facility census equaled 40 residents with 6 residents sample reviewed. Based on observations, interviews and record reviews, for 1 of 6 residents reviewed (#1010), the facility to implement written admission, transfer and discharge policies and retained a resident with incontinence (when the resident could not and would not participate in the management of the problem); and with behaviors that exceeded manageability. Findings included: -Surveyor review of resident #1010's clinical record on 2/29/08 revealed:	K3065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3065	Continued From page 18 1) Admission to the facility on 2/20/06 with diagnoses that included Dementia and Depression. 2) Resident Log (RL) notes by licensed nursing staff on 6/08/07, 7/07/07, 7/26/07 and 8/24/07 that documented the following behaviors exhibited by the resident: verbally abusive to staff and residents; urinating and defecating in public areas of the facility; naked from the waste down in public areas of the facility; refusing all medications and care from staff; and hitting other residents and staff. 3) Record of a visit to the physician's office by the resident and two staff members on 11/29/07 that contained documentation by the physician: "(resident) combative and we did not feel...should be restrained to do physical exam...caregivers with (resident) say he/she is acting as he/she usually does" The physician further documented "Dementia - aggressive behavior - has history of both visual and auditory hallucinations". On 2/29/08 at 12:30 p.m., surveyor observed the following: resident #1010 sitting at the dining room table in dementia unit; the resident's hair unkempt and uncombed; the resident would occasionally yell out "go away" or "leave me alone". A certified nurse aide (CNA) reported that resident #1010 would not allow staff to feed him/her and resisted all other care that staff tried to provide including dressing, toileting and showers. The CNA stated "it is hard to keep (resident) clean because he/she is combative". A certified medication aide (CMA) also reported that the resident had been refusing most of his/her medications on a consistent basis "for a long time now". Further review of the resident's record revealed: 1) MARS (medication administration records)	K3065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3065	Continued From page 19 from June 2007 to February 2008 that confirmed the resident frequently refused medications. 2) Weight record that documented the resident's weight in August 2007 as 120 pounds, September 2007 107 pounds, and a weight on February 25, 2008 of 88 pounds (a 32 pound weight loss from August 2007 to February 2008). On 2/29/08 at 12:45 p.m. and 3:05 p.m., the HCC confirmed that resident #1010 had behaviors that included consistent and frequent refusals to eat or drink and that the resident had suffered a significant weight loss since August of 2007. The HCC further confirmed that the resident exhibited the following behaviors: screaming or yelling out frequently; yelling at other residents and staff; resisted all care attempts by staff; was combative with staff during care; and refused all oral medications on a consistent basis. Further interviews with staff on 2/29/08 confirmed that resident #1010 was exhibiting the following behaviors: refusing to eat or drink fluids, refusing to take medications on a consistent basis, was combative and struggling with staff with all care attempts; was digging his/her fingernails into self and staff; and was incontinent of bowel and bladder and resistive and combative with all attempts to toilet the resident. Further review of the resident's clinical record on 3/04/08 revealed: 1) Skin assessment by an LPN (licensed practical nurse) dated 3/03/08 that documented: old bruises to right hip, right arm, left buttocks, scratches due to (finger)nails on left arm, scratch behind left ear, scratch on left shin, and 2 centimeter length pressure sores on both buttocks. 2) Admission to hospice care on 3/03/08 that	K3065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3065	Continued From page 20 included documentation by a hospice RN (registered nurse) that "resident agitated, pale, refusing food, fluids, and meds today...". The hospice RN further documented that resident "digs nails into self - reddened perirectal area with two open areas - probable UTI (urinary tract infection) - two 0.5 centimeter open areas to left and right of rectum - and significant weight loss". On 3/04/08 at 1:15 p.m., surveyor observed the following: resident #1010 sitting at dining room table with most of food offered to the resident thrown on the floor by the resident; the resident talking and yelling at unseen others (one time screaming to the wall behind him/her "I am going to kill you") - upsetting other residents (also with dementia) at the dining room table who yelled back at resident #1010; 2 certified staff removed resident #1010 from the dining room and walked the resident a few steps towards the resident's apartment in order to toilet the resident and to remove the resident from the dining room (due to resident #1010 upsetting other residents), the resident attempted to sit down on the floor while staff were walking the resident towards his/her apartment - the resident refused to go to apartment or to be toileted - screaming the whole time and digging his/her fingernails into the two staff's arms; the two staff had to drag the resident into the bathroom - remove the resident's pants and brief - then attempted to provide personal hygiene care due to the resident was incontinent of bowel; the resident continued to scream, scratch the two staff and kick at the staff; staff attempted to walk resident out of the bathroom after completing the toileting - resident continued to scream and continued combative with staff - staff had to drag the resident to a recliner chair in the resident's apartment; certified staff and surveyor noted that the resident had sustained a	K3065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3065	Continued From page 21 small skin tear to the right hand following the toileting. Interviews with several staff on 3/04/08 revealed that resident #1010 continued to exhibit the following behaviors: continued to refuse most food and fluids; continued to refuse oral medications; was hallucinating and talking or yelling at unseen others; was upsetting other residents in the dementia unit due to the yelling and screaming; was combative with all care - including digging his/her fingernails into self and staff during care; was especially combative with staff during toileting - screamed and fought the entire toileting process; and was verbally abusive towards some residents. On 3/04/08 at 5:30 p.m., surveyor asked the ED for a plan to deal with resident #1010's urgent medical needs related to the resident's continued behaviors of poor food and fluid intake, refusals of care (including incontinence management), and psychotic and combative behaviors. The ED stated that the plan would include consultation with the resident's family about the possibility that the resident required a transfer to another facility for appropriate treatment related to these urgent medical needs. On 3/04/08 at 6:00 p.m., the ED stated "I went back to look at (resident #1010) and I believe he/she is a danger to him/herself and other residents - I am going to contact the family to have (resident #1010) transferred to the hospital". On 3/04/08 at 7:30 p.m., resident #1010 was transported to a local hospital. The facility failed to implement admission, transfer and discharge policies and retained resident #1010 with incontinence of bowel and	K3065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3065	Continued From page 22 bladder that the resident could not and would not willingly participate in the management of the problem; and with ongoing behaviors that exceeded manageability by staff (that included refusals of care, resistance and combativeness with care attempts by staff; refusals of medications; and refusals of food and fluids). The resident suffered harm related to inadequate management of bowel and bladder incontinence (two stage 2 pressure ulcers to the resident's buttocks); and harm related to the resistive, combative and psychotic behaviors (injuries to self during care, digging fingernails into self, not receiving his/her medications on a consistent basis, and a significant weight loss).	K3065		
K3081 SS=E	26-39-243(b) Functional Capacity Screen (b) Designated staff at each facility shall conduct a screening to determine each resident ' s functional capacity, according to the following requirements: (1) At least once every 365 days; (2) following a significant change in condition as defined in K.A.R. 26-39-144; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. (Authorized by and implementing K.S.A. 2004 Supp. 39-923, K.S.A. 2004 Supp. 39-925, and K.S.A. 39-932; effective 11-04-05.) This RULE: is not met as evidenced by: KAR 26-39-243(b)(1)(2)	K3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3081	Continued From page 23 Facility census equaled 40 residents with 5 residents reviewed. Based on interviews and record reviews, for 2 of 5 residents reviewed (#1010 and #1009), the facility failed to conduct a functional capacity screen (FCS) at least once every 365 days for both residents and with a significant change in condition for resident #1010. Findings included: -Surveyor review of resident #1010's clinical record on 2/29/08 revealed: 1) Admission to the facility on 2/20/06. 2) FCS dated 8/15/06. Further review revealed no evidence of an annual FCS performed in August of 2007. The FCS dated 8/15/06 assessed the resident as physical assistance required for bathing and dressing, independent with toileting, transfers, walking/mobility and eating, physical assistance required for management of medications and medical treatments, continent of bladder, cognition scored with problems with short term memory and decision-making, no problems with communication and impaired vision and impaired decision-making as current or recent problems and risks. 3) Resident Log (RL) notes by licensed nursing staff on 6/08/07, 7/07/07, 7/26/07, and 8/24/07 that documented a significant change in the resident's condition that included the following behaviors exhibited by the resident: verbally abusive to staff and residents; urinating and defecating in public areas of the facility; naked from the waste down in public areas of the facility; refusing all medications and care from staff; and hitting other residents and staff. On 2/29/08 at 12:45 p.m., the Health Care Coordinator (HCC) confirmed that facility staff	K3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3081	Continued From page 24 failed to conduct an annual FCS for resident #1010 in August of 2007. The HCC further confirmed that resident #1010 experienced a significant change in physical, mental and psychosocial functioning/status sometime in June 2007 and required total assistance with most activities of daily living. The HCC reported that resident #1010 "unable to perform" bathing, dressing, toileting, management of medications or medical treatments and required physical assistance with transfers, walking/mobility and eating. The HCC confirmed that resident #1010 was totally incontinent of bowel and bladder; that the resident had severe dementia and had problems with all areas of cognition (including short and long term memory, memory/recall and decision making); had problems with communication skills - (that the resident usually understandable, but had the ability to only sometimes understand others); and that the resident's current or recent problems should also include falls and unsteadiness and socially inappropriate behavior. The HCC agreed that the facility failed to conduct a FCS following this significant change in the resident's physical, mental and psychosocial functioning/status. The facility failed to conduct a FCS at least on an annual basis for resident #1010, and following a significant change in the resident's condition related to all areas of activities of daily living (bathing, dressing, toileting, transfers, walking/mobility and eating); management of medications and medical treatments, bladder continence (totally incontinent); problems in all areas of cognition, problems with communication skills, and problems with falls and socially inappropriate behaviors.	K3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3081	Continued From page 25 -Surveyor review of resident #1009's clinical record on 3/04/08 revealed: 1) Admission to the facility on 5/31/99. 2) FCS dated 1/10/07. The resident's record lacked evidence of an annual FCS due in January 2008. On 3/04/08 at 4:35 p.m., the Executive Director (ED) confirmed that facility staff failed to conduct a FCS on resident #1009 at least every 365 days (annually). The facility failed to conduct a FCS for resident #1009 at least once every 365 days (annually).	K3081		
{K3082} SS=E	26-39-243(c), (d) Functional Capacity Screen (c) Designated staff at each facility shall ensure that the screening to determine each resident ' s functional capacity is accurately reflected on that resident ' s screening form. (d) Designated staff at each facility shall use the results of the functional capacity screening as a basis for determining the services to be included in the negotiated service agreement. (Authorized by and implementing K.S.A. 2004 Supp. 39-923, K.S.A. 2004 Supp. 39-925, and K.S.A. 39-932; effective 11-04-05.) This RULE: is not met as evidenced by: KAR 26-39-243(c) Facility census equaled 40 residents with 6 residents reviewed. Based on observations, record reviews and interviews, for 3 of 6 residents reviewed (#1005, #1007 and #1009), the facility	{K3082}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3082}	Continued From page 26 failed to ensure that each resident's functional capacity screen (FCS) accurately reflected each resident's functional capacity/status. Findings included: -On 3/05/08 at 6:55 a.m., surveyor observed resident #1005 sitting in a wheelchair in the resident's apartment with a CNA (certified nurse aide) in attendance. The CNA reported that resident #1005 required total care for dressing, bathing, toileting, and incontinence management. The CNA reported the resident required heavy physical assistance with transfers, eating (staff or resident's spouse assisted with feeding the resident), and that the resident only mobile by wheelchair - most of the time propelled by staff. Surveyor review of resident #1005's clinical record on 3/05/08 revealed a FCS dated 10/09/07 that coded the resident with '2' on dressing, toileting, and transfers (which indicated physical assistance needed for those activities); and coded the resident '1' with eating (indicating resident required supervision only with eating). On 3/05/08 at 1:30 p.m., the Executive Director (ED) confirmed that resident #1005's FCS dated 10/09/07 lacked accuracy related to dressing, toileting and transfers, and further confirmed they should be coded as a '3' (indicating resident unable to perform these activities and required total assistance from staff). The ED also confirmed that this FCS lacked accuracy related to eating and that eating should be coded as a '2' (indicating physical assistance required for eating). The facility failed to ensure the resident #1005's	{K3082}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3082}	Continued From page 27 FCS accurately reflected the resident's physical functioning/status related to dressing, toileting, transfers and eating. -On 3/05/08 at 7:20 a.m., surveyor observed the following: resident #1007 sitting in a wheelchair in the resident's apartment; a certified nurse aide (CNA) combing the resident's hair; the resident noted frail, alert, but confused to time and place; surveyor noted the resident with contractures of both arms and fingers of both hands and that the resident leaned severely to the left side of the wheelchair. The CNA reported that resident #1007 required total assistance with all activities of daily living (bathing, dressing, transfers, mobility per wheelchair, and feeding the resident). The surveyor observed the CNA washing the resident's face and then push the resident's wheelchair to the dining room for breakfast. On 3/05/08 at 8:05 a.m., surveyor observed resident #1007 sitting in the dining room of the facility with staff assisting the resident with eating. Surveyor review of resident #1007's clinical record on 3/05/08 revealed a FCS dated 1/11/08 that coded the resident as a '2' with bathing, dressing, toileting, transfers, walking/mobility (indicating the resident required physical assistance with these activities but able to participate in some aspect of these activities); and coded the resident as a '1' with eating (indicating the resident required supervision only with eating). On 3/05/08 at 12:40 p.m., the ED confirmed that resident #1007's FCS dated 1/11/08 lacked accuracy related to bathing, dressing, toileting, transfers, walking/mobility and eating. The ED	{K3082}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3082}	Continued From page 28 stated that bathing dressing, toileting, transfers and walking/mobility should be coded '3' - (indicating resident unable to perform these activities and required total staff assistance) and that eating should be coded '2' (indicating the resident required staff assistance with eating). The facility failed to ensure that resident #1007's FCS accurately reflected the resident's functional status related to bathing, dressing, toileting, transfers, walking/mobility and eating. -On 3/04/08 at 3:45 p.m., the ED reported "thought" the licensed nurse had completed a new FCS on resident #1009, but was unable to locate the new FCS. The ED identified that resident #1009's current FCS dated 1/10/07 lacked accuracy related to toileting, medication management, bladder continence and risk for falls. Surveyor review of resident #1009's FCS dated 1/10/07 indicated the resident was independent with toileting, required physical assistance with management of medications (indicating the resident able to participate in some aspect of medication management), was continent of bladder and failed to assess falls and unsteadiness as current or recent problems and risks. On 3/04/08 at 3:45 p.m., the Executive Director (ED) reported that resident #1009 was incontinent of bladder. The ED stated "toileting is our challenge - because (resident #1009) wants to re-use soiled garments and clothing - staff have to go in at night and remove the soiled clothing and launder them - then (resident's family member) comes in 2 - 3 times a week and	{K3082}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3082}	Continued From page 29 puts the clean clothing in resident's room - staff also have to strip the bed every morning because it is wet - we launder to sheets and remake the bed by noon". The ED confirmed that resident #1009's FCS did not accurately reflect the resident's status related to staff assistance with toileting needs and bladder incontinence. The ED also confirmed that resident #1009 unable to perform any aspect of medication management and required facility staff to administer all medications. On 3/04/08 at 4:35 p.m., the ED confirmed that resident #1009 began receiving PT and OT services on 2/11/08 and continued to receive these services related to the resident's unsteady gait and risk for falls. The ED agreed that the resident's FCS dated 1/10/07 lacked accuracy related to no identification/assessment that the resident was at risk for falls and unsteadiness. The facility failed to ensure that resident #1009's FCS accurately reflected the resident's current functional capacity/status related to toileting, medication management, bladder incontinence and risk for falls and unsteadiness.	{K3082}		
{K3092} SS=E	28-39-244(e) Negotiated Service Agreement (e) The negotiated service agreement shall be reviewed at least annually, revised if necessary, and revised more frequently if requested by the resident, the resident's legal representative, the family, if agreed to by the resident, the case manager or the facility. A licensed nurse shall be involved in revisions related to health care services.	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 30 This RULE: is not met as evidenced by: KAR 28-39-244(e) Facility census equaled 40 residents with 6 residents reviewed. Based on observations, interviews and record reviews, for 5 of 6 residents reviewed (#1005, #1007, #1009, #1010 and #1011), the facility failed to revise each resident's negotiated service agreement (NSA) regarding to revisions related to health care services needed by each resident. Findings included: -Surveyor review of resident #1010's clinical record on 2/29/08 revealed: 1) Admission to the facility on 2/20/06. 2) NSA dated 8/15/06 that contained the following health care services: Mobility - resident ambulates independently; Personal Hygiene/Continence - resident is independent with all toileting needs; Bathing/Showering - staff will provide verbal reminders to bathe 2 times a week - staff will help resident in/out of whirlpool, washing feet/back, or stand by assistance; Medications - staff supervises, assists and records all medications daily; Nutrition - staff will provide 3 meals a day in dining room; Specific Behaviors - resident has no specific behaviors at this time. 3) Resident Log (RL) notes by licensed nursing staff on 6/08/07, 7/07/07, 7/26/07, and 8/24/07 that documented a significant change in the resident's condition that included the following behaviors exhibited by the resident: verbally abusive to staff and residents; urinating and defecating in public areas of the facility; naked from the waste down in public areas of the facility; refusing all medications and care from staff; and	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 31 hitting other residents and staff. On 2/29/08 at 12:45 p.m., the Health Care Coordinator (HCC) confirmed that facility staff failed to revise resident #1010's NSA related to a significant change in the resident's physical, mental and psychosocial status that required a revision in the health care services to be provided to the resident by staff. The HCC reported that resident #1010 required the following health care services: total physical assistance with bathing and that staff showered the resident (did not use whirlpool); total physical assistance with toileting and staff management of the resident's bowel and bladder incontinence; physical assistance needed with mobility and transfers due to resident was unsteady and at risk for falls; and physical assistance needed with eating. The HCC further reported that resident #1010 exhibited behaviors including refusals of care, resistance and combativeness with care, socially inappropriate behaviors (screaming and yelling at other residents and staff); frequent refusals of medications, and frequent refusals of food and fluids. The HCC confirmed that resident #1010's NSA lacked revision related to health care services required for bathing, toileting and incontinence management, transfers and mobility, and eating. The HCC further confirmed that resident #1010's NSA lacked revision related to health care services required to address the resident's socially inappropriate behaviors, resistance and combativeness with care, refusals of medications, and refusals of food and fluids, and services needed to address the resident's risk for falls. The facility failed to revise resident #1010's NSA related to health care services required by the resident for bathing, toileting and incontinence	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 32 management, transfers and mobility assistance, and assistance with eating. The NSA also lacked revision related to health care services needed to address the resident's resistance and combativeness with care, refusals of care, refusal of medications, refusals of food and fluids, socially inappropriate behaviors and services to address the resident's risk for falls. -Surveyor review of resident #1009's clinical record on 3/04/08 revealed: 1) Admission to the facility on 5/31/99. 2) NSA dated 1/10/07 that included the following health care services: Personal Hygiene/Continence - resident is independent with all toileting needs; Bathing/Showering - staff will provide verbal reminders to bathe 2 times a week; Specific Behaviors - resident has no specific behaviors at this time. 3) Progress notes by the resident's physician on 1/03/08 that contained documentation that the resident's balance and walking "seem to be diminishing" and resident complains of "less steady on feet". 4) Physician orders dated 2/07/08 for PT/OT (physical therapy/occupational therapy) for gait instability. On 3/04/08 at 3:45 p.m., the Executive Director (ED) reported that resident #1009 was resistant to bathing and needed a lot of prompting and occasional staff assistance and supervision. The ED further reported that the resident was incontinent of bladder. The ED stated "toileting is our challenge - because (resident #1009) want to re-use soiled garments and clothing - staff have to go in at night and remove the soiled clothing and launder them - then (resident's family member) comes in 2 - 3 times a week and puts	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 33 the clean clothing in resident's room - staff also have to strip the bed every morning because it is wet - we launder to sheets and remake the bed by noon". The ED confirmed that resident #1009's NSA lacked revision related to health care services required for increased bathing assistance/supervision, incontinence management and behaviors associated with resistance to bathing, resistance to wearing clean clothes, and staff and family management of the soiled garments, clothing and bed linens. The ED reported "unaware" if the resident was receiving services of PT or OT, but would call the agency and check. On 3/04/08 at 4:35 p.m., the ED confirmed that resident #1009 began receiving PT and OT services on 2/11/08 and continued to receive these services (related to the resident's risk for falls and gait instability). The ED confirmed that resident #1009's NSA lacked revision related to the services provided by PT and OT to address the resident's risk for falls. The facility failed to revise resident #1009's NSA related to health care services required for bathing, toileting and incontinence management, behaviors of resistance to bathing and resistance to wearing clean clothing, increased staff and family laundry services for management of the resident's soiled clothing and bed linens, and services provided by PT and OT to address the resident's risk for falls. -Surveyor review of resident #1011's clinical record on 3/05/08 revealed: 1) Admission to the facility on 12/07/07. 2) NSA dated 1/07/08 that included the following health care services: Falls Management - staff	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 34 will report any instability to nurse; staff will provide verbal cueing to use walker when indicated; staff will visually attempt to check on resident every 30 minutes and remind resident to use walker at all times; staff will remind resident to use call light for assistance when needing to get up out of a chair or bed; staff will remove any environmental objects to reduce resident's potential for tripping or falling. 3) Resident Log notes 1/25/08, 1/26/08 and 3/05/08 documented 3 falls experienced by the resident - each fall with injuries. On 3/05/08 at 9:00 a.m., the Executive Director (ED) reported that resident #1011 currently received PT visits and treatments for fall prevention. The ED confirmed that the health care services for fall prevention listed in the resident's NSA dated 1/07/08 were not effective to prevent falls due to the resident could not remember to use call light to call for assistance before transfers, resident could not remember to use his/her walker, and that the facility lacked adequate staff to check on the resident every 30 minutes, especially at night due to only 1 staff person worked on the assisted living side of the facility on night shift. The ED agreed that resident #1011's NSA needed revised to reflect more appropriate health care services to address the resident's risk for falls, and to include the services of PT currently being provided by an outside resource to address the resident's instability and risk for falls. The facility failed to revise resident #1011's NSA related to health care services necessary to address the resident's continued risk for falls, and to include the services of PT currently being provided by an outside resource for fall prevention.	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 35	{K3092}		

-On 3/05/08 at 6:55 a.m., surveyor observed resident #1005 sitting in a wheelchair in the resident's apartment with a CNA (certified nurse aide) in attendance. The CNA reported that resident #1005 required total care for dressing, bathing, toileting, and incontinence management. The CNA reported the resident required heavy physical assistance with transfers, eating (staff or resident's spouse assisted with feeding the resident), and that the resident only mobile by wheelchair - most of the time propelled by staff.

Surveyor review of resident #1005's clinical record on 3/05/08 revealed an NSA dated 10/09/07 that included the following health care services: Physical Abilities - resident is able to ambulate independently in room to the bathroom and with stand-by assistance from staff - resident will ambulate with walker; Personal Hygiene/Continence - resident will notify staff when needing assistance with toileting; Nutrition - staff prepares pureed meals due to difficulty chewing - staff will serve three meals a day in dining room.

On 3/05/08 at 8:05 a.m. surveyor observed staff in the dining room assisting resident #1005 with eating. The resident attempted to feed self at times, but made poor attempts to eat. A CNA reported "he/she cannot really feed him/herself - we have to assist (the resident)".

On 3/05/08 at 1:30 p.m., the Executive Director (ED) stated that he/she was aware that resident #1005 was "total care". The ED confirmed that resident #1005's NSA dated 10/09/07 lacked revision related to the following health care services: Physical Abilities - resident mobile by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 36 wheelchair only and can no longer walk with a walker - resident cannot ambulate independently; Personal Hygiene/Continence - the resident will call staff for assistance, but staff assist the resident with all aspects of toileting including providing personal hygiene following each toileting or incontinent episode. The ED further reported that staff check the resident every 2 hours for incontinence and "usually have to change (the resident) at least one time in the night". The ED further confirmed that Nutrition services needed revised as the resident required staff or spouse assistance with feeding. The facility failed to revise resident #1005's NSA related to the following needed health care services: physical assistance required for transfers and mobility by wheelchair only; total staff assistance with toileting and incontinence management; and staff or spouse assistance with eating. -On 3/05/08 at 7:20 a.m., surveyor observed the following: resident #1007 sitting in a wheelchair in the resident's apartment; a certified nurse aide (CNA) combing the resident's hair; the resident noted frail, alert, but confused to time and place; surveyor noted the resident with contractures of both arms and fingers of both hands and that the resident leaned severely to the left side of the wheelchair. The CNA reported that resident #1007 required total assistance with all activities of daily living (bathing, dressing, transfers, mobility per wheelchair, and feeding the resident). The surveyor observed the CNA washing the resident's face and then push the resident's wheelchair to the dining room for breakfast. On 3/05/08 at 8:05 a.m., surveyor observed	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 37 resident #1007 sitting in the dining room of the facility with staff assisting the resident with eating. Surveyor also observed resident attempting to pick up scrambled eggs with contractured hand/fingers and put the eggs in his/her mouth - most of the eggs fell on the resident's lap or floor. Surveyor also observed resident attempted to use spoon, but most food fell off the spoon before the resident could get spoon to his/her mouth. A CNA in the dining room reported that resident #1007 required assistance with eating in order for the resident to receive adequate nutrition. Surveyor review of resident #1007's NSA dated 1/11/08 included the following services: Physical Abilities - resident requires assistance of staff to ambulate/transfer, staff will assist by walking with resident, holding on to his/her hands to guide (resident), staff will provide complete mobility assistance in the wheelchair; Stability/Falls - included that staff will provide 30 minute visual checks to reduce risk for falls and check for any needs (resident) has as resident is too weak to pull the call cord (light); Nutrition - staff prepares plate by cutting meats, buttering bread, etc. for resident due to blindness - staff will notify resident of food items on plate - resident frequently per choice will eat food with fingers, however is able to use utensils - resident will at times drop food onto self - staff will assist as indicated. On 3/05/08 at 12:40 p.m., the ED confirmed that resident #1007 required total care from staff. The ED further confirmed that resident #1007's NSA dated 1/11/08 lacked revision related to the following needed health care services: - the resident required total physical assistance of 1 or 2 two staff for all transfers, the resident could no longer use a walker or walk with assistance; that staff were not realistically able to check on the	{K3092}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
{K3092}	Continued From page 38 resident every 30 minutes due to a lack of staff on all shifts, especially night shift, to accomplish every 30 minutes checks - that staff checked on the resident every 2 hours at night for incontinence - that due to the resident's immobility, staff repositioned the resident every 2 hours during the day (transfer to toilet, or transfer to another chair in the facility - in order to prevent skin breakdown) - and that the resident required staff to feed (the resident) in order for the resident to receive adequate nutrition. The facility failed to revise resident #1007's NSA related to the following health care services needed by the resident: total assistance by 1 or 2 staff with all transfers; mobility by wheelchair only propelled by staff; every 2 hour checks by staff at night to check for incontinence; repositioning every 2 hours during the day to prevent skin breakdown; staff assistance with feeding at all mealtimes in order to ensure adequate nutrition.	{K3092}		
K3105 SS=E	28-39-244j(1),(2),(3) Negotiated Service Agreement When the resident's negotiated service agreement includes the use of outside resources, the facility shall: (1) Provide the resident, the resident's legal representative, the family, if agreed to by the resident, and the case manager a list of service providers available to provide the needed service; (2) assist the resident, when requested, in contacting outside resources for services; and (3) monitor the services provided by the outside resource and act as an advocate for the resident when services do not meet professional stndards of practice. This RULE: is not met as evidenced by: KAR 28-39-244(j)(3)	K3105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3105	Continued From page 39 Facility census equaled 40 residents with 6 residents sample reviewed. Based on record reviews and interviews, for 2 of 6 residents reviewed (#1009 and #1011), the facility failed to monitor the services provided by an outside resource in order to act as an advocate for the resident if the services did not meet professional standards of practice. Findings included: -Surveyor review of resident #1009's clinical record on 3/04/08 revealed: 1) Physician orders dated 2/07/08 for PT/OT (physical therapy/occupational therapy) for gait instability. 2) Further review of the resident's record revealed an OT evaluation on 2/11/08. The resident's record lacked evidence of a PT evaluation or any treatment. On 3/04/08 at 3:45 p.m., the Executive Director (ED) reported "unaware" if the resident was receiving services of PT or OT, but would call the outside agency and check. On 3/04/08 at 4:35 p.m., the ED confirmed that resident #1009 began receiving PT and OT services on 2/11/08 and continued to receive these services (related to the resident's risk for falls and gait instability). The ED confirmed that the due to the fact that the facility was unaware of these services being provided to the resident, and no evidence of a PT evaluation or ongoing treatment, the facility could not be monitoring these services provided by an outside resource. The facility failed to monitor the services of PT	K3105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3105	Continued From page 40 and OT provided to resident #1009 by an outside resource in order to act as an advocate for the resident if those services did not meet professional standards of practice. -Surveyor review of resident #1011's clinical record on 3/05/08 revealed: 1) Physician's order dated 1/30/08 for PT to evaluate and treat. 2) OT evaluation on 2/08/08 with records of OT visits up to 2/29/08. 3) The resident's record contained a PT evaluation dated 1/31/08 but lacked evidence of and further treatments by PT. On 3/05/08 at 9:00 a.m., the ED confirmed that resident #1011 currently receiving PT and OT. The ED further confirmed that the resident's record contained an evaluation by PT dated 1/31/08, but lacked any evidence of further treatments. The ED stated he/she would call the outside agency and make sure the resident had been receiving PT services/treatments. The ED agreed that the facility had failed to monitor the services of PT being provided to the resident by an outside resource. On 3/05/08 at 9:43 a.m., the outside agency faxed a record of PT services and treatments currently being provided to resident #1011. The facility failed to monitor the services of PT provided to resident #1011 by an outside resource in order to act as an advocate if those services did not meet professional standards of practice.	K3105		
K3261 SS=E	28-39-250(e) 10 Resident Record	K3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3261	Continued From page 41 The resident record shall contain at least the following: ... (10) the documentation of all incidents, symptoms and other indications of illness or injury including the date, the time of occurrence, the action taken and the results of action. This RULE: is not met as evidenced by: KAR 28-39-250(e)(10) Facility census equaled 40 residents with 6 residents reviewed. Based on record reviews and interviews, for 2 of 6 residents reviewed (#1010 and #1005), the facility failed to ensure each resident's record contained the documentation of all incidents and other indications of injury including the date, the time of occurrence, the action taken and results of actions taken. Findings included: -On 3/04/08, surveyor reviewed resident shift reports for resident #1010 (completed by certified staff) that documented resident #1010 fell on 1/21/08, 1/25/08, 2/01/08, 2/14/08 and 2/18/08. The certified staff documented that the resident received lacerations to the head following the falls on 1/25/08 and 2/14/08. Further review of resident #1010's clinical record on 3/04/08 revealed a lack of documentation by the licensed nurse of any of these falls, the dates or times of the falls, any actions taken by staff and the results of actions taken by staff. Interviews with several staff on 3/04/08 revealed the following: certified staff confirmed that resident #1010 fell on 1/21/08, 1/25/08, 2/01/08, 2/14/08 and 2/18/08 as documented in shift	K3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3261	Continued From page 42	K3261		

reports. These interviews revealed that the resident sustained a laceration to the back of the head following the fall on 1/25/08, and a laceration behind the resident's left ear following the fall on 2/14/08. The certified staff reported to surveyor that following these two falls with head injuries (on 1/25/08 and 2/14/08), the staff immediately notified the HCC about the falls/injuries/lacerations, but the HCC refused to come to the facility to assess the resident's injuries and gave no instructions to the certified staff on what they should do about the lacerations/head injuries. Certified staff reported that they notified the resident's family after the fall on 2/14/08 because they felt the laceration needed stitches - and that a family member came to the facility but was unable to take the resident to the hospital because the resident was so combative. The certified staff reported that they called the HCC back on 2/14/08 to report this, and to again inform the HCC that they (the certified staff) felt the resident required stitches and treatment for the laceration. The certified staff stated that the HCC again refused to come to the facility and told the staff it was the family's decision and responsibility to obtain treatment for the resident. The certified staff confirmed that the resident received no treatment for the laceration/head injury following the fall on 2/14/08, and further confirmed that the resident's physician was not contacted by the HCC/nurse following either fall on 1/25/08 or 2/14/08.

On 3/04/08 at 2:00 p.m., the Executive Director (ED) confirmed that resident #1010's clinical record lacked documentation by the licensed nurse/HCC of the falls suffered by the resident on 1/21/08, 1/25/08, 2/01/08, 2/14/08 and 2/18/08.

The facility failed to ensure that resident #1010's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3261	Continued From page 43 clinical record contained documentation of all incidents (falls) and symptoms of injuries (lacerations with 2 of those falls), including the date and time of occurrence, any actions that may have been taken by staff and the results of those actions. -On 3/05/08 at 1:30 p.m., the Executive Director reported was aware of a fall suffered by resident #1005 "sometime in January of this year (2008)" - not sure what exact date - but believed the resident slid out of recliner chair in the resident's apartment onto the floor. The ED stated "I am not aware of any injuries - I know (the resident) knocked over a side table beside the chair when he/she fell - I called the nurse". Surveyor and ED reviewed the resident's clinical record for documentation of this fall. The ED confirmed the resident's record lacked evidence of this fall including the date and time of occurrence, any actions taken by staff and the results of those actions. The facility failed to ensure that resident #1005's clinical record contained documentation of all incidents (a fall sometime in January 2008), including the date and time of occurrence, any actions taken by staff and the results of those actions.	K3261		
K3305 SS=E	28-39-253(a)(b) Infection Control (a) The assisted living and residential health care facility shall provide a safe, sanitary and comfortable environment for residents. (b) The facility shall develop and implement policies and procedures to prevent and control the spread of infections. These policies and	K3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3305	Continued From page 44 procedures shall include the following: (1) Universal precautions to prevent the spread of blood-borne pathogens; (2) handwashing; (3) laundry and proper handling of soiled and clean linens; (4) food service sanitation; This RULE: is not met as evidenced by: KAR 28-39-253(a) Facility census equaled 40 residents with 6 residents sample reviewed. Based on observations and interviews, for 2 of 6 residents reviewed (#1008 and #1011), the facility failed to provide a sanitary environment for these residents. Findings included: -On 2/29/08 at 11:45 a.m., surveyor observed the following: resident #1008 sitting in a wheelchair in his/her apartment. The apartment contained a strong and offensive odor, was extremely cluttered and popcorn and other food particles noted scattered all over the resident's floor. Surveyor also noted smeared food items and dirty dishes on the resident's kitchen counter. On 2/29/08 at 11:55 a.m., the Health Care Coordinator (HCC) confirmed that resident #1008's environment in his/her apartment "was bad". The HCC stated that the resident did not like staff to clean the apartment, and confirmed that the resident left food items scattered all over the apartment. The HCC stated "we had to get an	K3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K3305	Continued From page 45 exterminator out here last week because (resident #1008's) apartment was full of ants" related to all the food and dirty dishes left out. The HCC stated "we could easily increase the housekeeping from one time a week to at least 3 - 4 times a week". The facility failed to provide a sanitary environment for resident #1008. -On 3/05/08 at 7:05 a.m., surveyor observed ants crawling all over resident #1011's apartment kitchen counter, sink and around the dirty dishes in the sink. A Certified Medication Aide (CMA) was in the resident's apartment with the surveyor and acknowledged the observation of the ants. On 3/05/08 at 9:00 a.m., surveyor showed the Executive Director (ED) resident #1011's apartment and both the surveyor and ED noted the ants on the kitchen counter and sink. The facility failed to provide a sanitary environment for resident #1011 related to insects/ants crawling all over the resident's apartment kitchen area, sink and dishes.	K3305		
K 135 SS=G	28-39-147(g) NOTIFICATION OF CHANGES (g) Notification of changes. (1) An adult care home shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or designated family member when there is: (A) An accident involving the resident which results in injury and has the potential for requiring	K 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K 135	Continued From page 46 a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The adult care home shall promptly notify the resident, the resident's legal representative, or designated family member when there is a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 28-39-147(g)(1)(A)(B) Facility census equaled 40 residents with 6 residents sample reviewed. Based on observations, interviews and record reviews, for 2 of 6 residents reviewed (#1010 and #1011), the facility failed to immediately inform and consult with each resident's physician following accidents (falls) that resulted in injuries and had the potential for requiring a physician's intervention. The facility also failed to immediately inform and consult with resident #1010's physician following a significant change in the resident's status that resulted in significant weight loss. Findings included: -Surveyor review of resident #1010's clinical record on 2/29/08 revealed: 1) Admission to the facility on 2/20/06 with diagnoses that included Dementia and Depression.	K 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K 135	Continued From page 47 2) Discharge form dated 8/13/07 from a hospital included the discharge diagnosis of vascular dementia with behavioral disturbances with depression, and included a diet order for finger foods and vanilla boost (dietary supplement) bid (twice daily). 3) Physician's order fax form dated 8/16/07 that contained documentation to the physician by the facility nurse that the resident refused to drink vanilla boost and an order received to discontinue the boost. 4) Notes by the physician's office nurse dated 11/28/07 that documented a call from the facility nurse/Health Care Coordinator (HCC) to report "resident not doing very well" - due to pulse low, poor appetite and weight loss (current weight 124). The office nurse noted that the physician's office last weight on file as 129 (which would have indicated only a 5 pound weight loss). On 2/29/08 at 12:30 p.m., surveyor observed the following: resident #1010 sitting at dining room table in dementia unit with a plate of food in front of resident that included meat, mashed potatoes, vegetables - no finger foods observed; the resident kept his/her arms folded and made no attempts to eat or drink; the resident would occasionally yell out "go away" or "leave me alone". A certified nurse aide (CNA) reported that resident #1010 would not allow staff to feed him/her. The CNA stated that the resident "needs finger foods - he/she has not been eating well". The CNA confirmed that the resident refused to drink the boost supplement. The CNA stated "(the resident) hates it (the boost) - he/she thinks it is for babies". Further review of the resident's record revealed: 1) Weight record log that documented the resident's weight in August 2007 as 120 pounds,	K 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K 135	Continued From page 48 September 2007 as 107 pounds, November 26, 2007 weight of 99 pounds, and a weight on February 25, 2008 of 88 pounds (a 32 pound weight loss from August 2007 to February 2008). 2) Dietary consultation report dated 12/18/07 by a licensed dietitian that documented "no weight losses via nursing" and contained the signature of the facility nurse/HCC. 3) Resident Log notes by the HCC on 2/19/08 that nurse contacted the resident's physician for telephone order for boost TID (three times a day). On 2/29/08 at 12:45 p.m. and 3:05 p.m., the HCC confirmed that resident #1010 was refusing to eat or drink boost (and other fluids) and confirmed the resident had suffered a significant weight loss since August of 2007. The HCC stated that he/she obtained another order for boost on 2/19/08 but the resident refused to drink it. The HCC admitted that he/she had never notified the resident's physician of the significant weight loss occurring from August 2007 to February 2008. The HCC confirmed that he/she had reported an inaccurate weight to the physician's office on 11/28/07 (documented by the physician's office nurse as 124 pounds, but facility records showed a weight obtained on 11/26/07 as 99 pounds). The HCC stated "I don't know why I reported that weight (of 124 pounds)". The HCC then stated that he/she obtained another order for boost on 2/19/08, however did not report the continued significant weight loss to the physician. On 3/04/08, surveyor reviewed resident shift reports (completed by certified staff) that documented resident #1010 fell on 1/21/08, 1/25/08, 2/01/08, 2/14/08 and 2/18/08. The certified staff documented that the resident received lacerations to the head following the falls on 1/25/08 and 2/14/08. Further review of	K 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K 135	Continued From page 49 resident #1010's clinical record on 3/04/08 revealed a lack of documentation by the licensed nurse of any of these falls or evidence that the resident's physician was contacted following the falls on 1/25/08 and 2/14/08 that resulted in lacerations to the resident's head. Interviews with several staff on 3/04/08 revealed the following: certified staff confirmed that resident #1010 fell on 1/21/08, 1/25/08, 2/01/08, 2/14/08 and 2/18/08 as documented in shift reports. These interviews revealed that the resident sustained a laceration to the back of the head following the fall on 1/25/08, and a laceration behind the resident's left ear following the fall on 2/14/08. The certified staff reported to surveyor that following these two falls with head injuries (on 1/25/08 and 2/14/08), the staff immediately notified the HCC about the falls/injuries/lacerations, but the HCC refused to come to the facility to assess the resident's injuries and gave no instructions to the certified staff on what they should do about the lacerations/head injuries. Certified staff reported that they notified the resident's family after the fall on 2/14/08 because they felt the laceration needed stitches - and that a family member came to the facility but was unable to take the resident to the hospital because the resident was so combative. The certified staff reported that they called the HCC back on 2/14/08 to report this, and to again inform the HCC that they (the certified staff) felt the resident required stitches and treatment for the laceration. The certified staff stated that the HCC again refused to come to the facility and told the staff it was the family's decision and responsibility to obtain treatment for the resident. The certified staff confirmed that the resident received no treatment for the laceration/head injury following the fall on	K 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K 135	Continued From page 50 2/14/08, and further confirmed that the resident's physician was not contacted by the HCC/nurse following either fall on 1/25/08 or 2/14/08. The facility failed to immediately notify and consult with resident #1010's physician following a continued and rapid weight loss as documented on weight log records in the resident's clinical record from August 2007 to February 2008. The HCC admitted that he/she notified the physician that the resident refused to drink boost (in August of 2007) and requested another order for boost (on 2/19/08), but failed to inform the physician that the resident was also refusing foods and fluids on a consistent basis and rapidly losing weight. The resident suffered harm - a significant weight loss (32 pounds from August 2007 to February 2008). The facility also failed to immediately notify and consult with resident #1010's physician following falls on 1/25/08 and 2/14/08 that resulted in lacerations to the resident's head and had the potential for requiring a physician's intervention. The resident suffered harm from the lack of appropriate medical evaluation and treatment of these head injuries. -Surveyor review of resident #1011's clinical record on 3/05/08 revealed: 1) Resident Log (RL) entry 1/25/08 at 12:00 noon by the Executive Director (ED): "Resident went to sit in chair during lunch and missed the chair. Resident landed on right side and had a skin tear on right elbow. Nurse and family notified". The notes lacked evidence that the resident's physician was contacted about the fall and skin tear. 2) RL 1/26/08 at 5:15 a.m. by the HCC: "This nurse was called because resident was anxious and was observed crawling on the floor. Resident	K 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023017	A. BUILDING _____ B. WING _____	R-C 03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR OF LAWRENCE	3220 PETERSON RD LAWRENCE, KS 66049

(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
K 135	Continued From page 51 obtained rug burns on all toes and both knees. Resident also had a skin tear on right hand". The notes lacked evidence that the resident's physician was notified about the incident and injury. On 3/05/08 at 11:40 a.m., the ED admitted that he/she didn't know if the HCC had contacted resident #1011's physician following the falls on 1/25/08 and 1/26/08 that resulted in injuries. The ED agreed that the resident's record lacked evidence of any notification of the resident's physician regarding these falls and injuries. The facility failed to provide evidence that resident #1011's physician was immediately notified following falls on 1/25/08 and 1/26/08 that resulted in injuries and had the potential for requiring a physician's intervention.	K 135		