

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175531</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/06/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ATCHISON SENIOR VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1419 N 6TH STREET ATCHISON, KS 66002</b>	
(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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 159 SS=E	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available</p>	F 159		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	<p>Continued From page 1</p> <p>through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents and 28 of the residents had personal funds accounts. Based on interview and record review the facility failed to ensure residents (#7 and #12) with personal funds accounts received quarterly statements.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- During an interview on 9/27/16 at 8:32 a.m., resident #7's family indicated the resident had a personal funds account and stated he/she never received a statement of the resident's personal funds from the facility.</li> </ul> <p>An interview on 9/27/16 at 10:20 a.m. with resident #12's responsible party confirmed the resident had a personal funds account, was unaware of how much money the resident had in the account, and he/she did not receive quarterly statements from the facility.</p> <p>Review of the personal funds accounts verified</p>	F 159			

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F 159	Continued From page 2 that resident #7 and #12 had personal funds accounts. Record review lacked evidence of sending quarterly statements to these residents.  During an interview on 9/28/16 at 4:12 p.m., administrative staff B stated the facility sends out quarterly statements if the resident's accounts contain more than \$50. He/she confirmed resident #7 and #12 did not receive quarterly statements.  During an interview on 9/29/16 at 9:04 a.m., administrative staff A was unaware that the facility did not send out quarterly statements to residents with account totals less than \$50.	F 159			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280			

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F 280	<p>Continued From page 3 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. The sample included 13 residents. Based on record review, observation and interview, the facility failed to revise the comprehensive care plan to identify the use of a side rail and/or other positioning devices for 1 of 2 residents sampled (#3) for accidents.</p> <p>Findings included: - The September 2016 signed physicians order sheet (POS) documented resident #3 admitted with diagnoses that included: Schizoid Personality Disorder, (a psychotic disorder characterized by gross distortion of reality, disturbances of language, communication and fragmentation of thought) and anxiety (an emotion characterized by an unpleasant state of inner turmoil, often accompanied by nervous behavior).</p> <p>The 8/22/16 Significant Change Minimum Data Set (MDS) assessment documented the resident had a Brief Interview for Mental Status (BIMS) score of 9 which indicated he/she had moderate cognitive impairment. The activities of daily living (ADLs) documented the resident required extensive assistance of 1 staff member with eating, personal hygiene and locomotion on the unit, 2 staff assistance with dressing, toileting, transfers and bed mobility and was incontinent of bowel and bladder.</p> <p>The 8/22/16 significant change Care Area</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>Assessment (CAA) recorded the resident required more help with all ADLs and was unable to communicate needs as he/she did before.</p> <p>The resident's Care Plan revised on 9/6/16 directed two staff to assist with a gait belt when getting in and out of bed when he/she had increased mobility and was participating to stand and two staff assistance with a sit to stand lift when he/she felt unable to assist with transfers. The care plan lacked documentation of a side rail and/or other positioning devices.</p> <p>Review of the clinical record revealed side rail assessments dated 2/2/15, 5/24/15, 5/20/16, and 8/20/16, documented the resident used a side rail for positioning and recorded no safety concerns for the resident's side rail use.</p> <p>Observation on 9/26/16 at 2:19 PM revealed the resident's bed side rail was in the up position and had two 6 inch by 7 inch gaps between the vertical bars.</p> <p>Observation on 9/28/16 at 9:43 AM revealed this same side rail was lowered and zip tied to bed so it could not be moved. A positioning bar was installed on the bed.</p> <p>During an interview on 09/28/16 at 2:39 PM direct care staff I stated he/she didn't know if the resident had any problems with her side rails.</p> <p>During an interview on 9/29/16 at 11:45 AM administrative licensed nurse C stated if a resident wanted a side rail, the treatment team discussed whether or not he resident was in danger of entrapment. If the resident was cognitively intact and wanted a side rail, the team</p>	F 280			

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F 280	Continued From page 5 considered it 'like a diabetic wanting a piece of cake, we could not keep them from eating it.'  According to U.S. Food and Drug Administration (FDA' s) "Hospital Bed System Dimensional and Assessment Guidance to reduce Entrapment" document, dated 3/10/2006, the gaps within rails should be less than 4 ¾ inches to prevent head or body entrapment.  The facility's undated Side Rail policy documented: Side rails could only be used after a side rail assessment was done, and side rails use was warranted for positioning, assisting in and out of bed and/or other uses as warranted. The policy acknowledged the inappropriate use of side rails could be a danger; side rails could not be used based on the request of a family member even if they hold power of attorney. Alert and oriented, could choose a side rail only after they were educated to the dangers they posed.  The facility's undated Side Rail policy lacked documentation related to the FDA guidelines for side rail use.  The facility failed to revise the comprehensive care plan to indicate the use of a side rail and/or positioning bar for this cognitively impaired dependent resident with decreased mobility.	F 280			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282			

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F 282	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. Based on record review and interview, the facility failed to ensure that certified staff administered medications, intermittently over a 4 month period for 3 sampled residents (#1, #3, and #12) on one hall when one Certified Medication Aide's state certification expired.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- On 9/28/16 at 9:45 A.M. record review of employee files revealed, the facility employed 7 (full and part-time) Certified Medication Aides. A review of the medication aides' certifications revealed direct care staff member S certification expired on 9/25/15 and was renewed with the Kansas State Board of Licensure on 1/26/16.</li> </ul> <p>Review of the facility working schedule from September 2015 to January 2016 revealed this same staff member administered medications to at least three sampled residents (#1, #3, and #12) for day and evening shifts for a total of 313 doses over - days while his/her medication certification was expired. There was no evidence of medication errors during this time period.</p> <p>On 9/29/16 at 1:00 P.M. administrative staff A stated the facility did not have a policy related to the routine examination of staff certifications.</p> <p>On 9/28/16 at 4:25 P.M. interview with administrative licensed nurse D stated the Medication Aide CMA S did work full time at the facility, during the above mentioned 4 month period. Administrative staff A and administrative</p>	F 282			

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F 282	Continued From page 7 licensed nurse D both stated they were unaware staff member S's certification had lapsed and he/she passed medications during that time. Administrative staff A stated he/she would report the instance and conduct an investigation. Administrative staff A stated the computer would normally flag staff members whose license/certification was up for renewal.  The facility failed to ensure sampled residents (#1, #3, and #12) received medications from a state Certified Medication Aide from September 25th 2015 thru January 25th 2016.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to implement interventions to ensure resident side rails did not have large gaps, a possible entrapment hazard for 2 sampled residents (#3 and #46) and 5 non-sampled residents (#23, #59, #61, #39 and #47) for the 1 of 4 days of the survey.  Findings included:	F 323			

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F 323	<p>Continued From page 8</p> <p>- The Physicians Order Sheet dated 8/31/16 for resident #3 recorded he/she had diagnoses of Schizoid Personality Disorder, (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and anxiety disorder, (a major mental illness that caused people to have episodes of severe high and low).</p> <p>The 8/22/16 Significant Change Minimum Data Set (MDS) assessment documented short and long term memory problems and moderate impairment for decision making. The Activity of Daily Living (ADL) noted the resident required extensive assistance of 2 staff for dressing, toileting, bed mobility and transfers and 1 staff assistance for eating, personal hygiene and locomotion on the unit. The Brief Interview for Mental Status (BIMS) recorded a score of 9 which indicates moderate cognitive impairment. The resident is incontinent of bowel and bladder.</p> <p>The 8/22/16 Care Area Assessment (CAA) recorded the resident to be requiring more help with all his/her ADLs and was unable to communicate his/her needs as he/she did before.</p> <p>The resident's Care Plan revised on 9/6/16 lacked documentation instructing the staff of the possibility of injury due to entrapment in the side rails.</p> <p>Record review for side rail assessments dated 2/2/15, 5/24/15, 5/20/16 and 8/20/16 did not identify safety concerns for the resident.</p> <p>During an observation on 9/26/16 at 2:19 PM the</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>side rail on resident #3's bed was in the raised position and had 2 - 6 inch by 7 inch openings.</p> <p>During an observation on 9/28/16 at 9:43 AM the side rail was lowered and zip tied to bed so it could not be moved.</p> <p>During an interview on 9/29/16 at 11:45 AM Administrative Licensed nurse C stated if a resident wanted a side rail their treatment team discussed if they are in danger of entrapment. If the resident is cognitive and wanted a side rail we consider it 'like a diabetic wanting a piece of cake, we cannot keep them from eating it.'</p> <p>Undated facility Side Rail Protocol documents side rails may only be used after a side rail assessment is done, and use of side rails is warranted for positioning, assisting in and out of bed or other uses as warranted. As the inappropriate use of side rails can be a danger, side rails may not be used strictly on the request of a family member even if they hold power of attorney. Residents, if alert and oriented, may choose a side rail only after they have been educated to the dangers they pose.</p> <p>The facility failed to ensure that the environment remained free of entrapment hazards due to large gaps in the side rails for this dependent resident.</p> <p>- Observation on 9/28/16 at 9:30 A.M. during a tour of the facility revealed the following residents' beds had side rails or positioning bars with gaps within the rails greater than 4.75 inches.</p> <p>Sampled resident #46's upside down U shaped</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>side rail/ positioning bar had a gap that measured 24 inches long by 10.5 inches wide.</p> <p>Resident #23's bed side rail gap measured 7 inches long by 7 inches wide.</p> <p>Resident #59's bed side rail gaps measured 7.5 inches long by 7.5 inches wide.</p> <p>Resident # 61's bed side rail with gap measured 8 inches long by 7.75 inches wide.</p> <p>Resident #39's bed side rail had a large positioning bar with gaps that measured 10.5 in by 8 in and 10.5 by 7 inches.</p> <p>Resident #47's bed side rail had 3 sections which measured 8.5 inches long by 7.75 inches wide.</p> <p>According to U.S. Food and Drug Administration (FDA)'s "Hospital Bed System Dimensional and Assessment Guidance to reduce Entrapment " document, dated 3/10/2006, the gaps within rails should be less than 4 ¼ inches to prevent head or body entrapment".</p> <p>On 9/29/16 at 1:30 A.M. administrative staff A acknowledged some side rails were not within the FDA guidelines for bedside rails.</p> <p>The facility's undated Side Rail policy documented: Side rails could only be used after a side rail assessment was done, and side rails use was warranted for positioning, assisting in and out of bed and/or other uses as warranted. The policy acknowledged the inappropriate use of side rails could be a danger; side rails could not be used based on the request of a family member even if they hold power of attorney. Alert and</p>	F 323			

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F 323	Continued From page 11 oriented, could choose a side rail only after they were educated to the dangers they posed.  The facility's undated Side Rail policy lacked documentation related to the FDA guidelines for large gaps and entrapment risks for side rail use.  The facility failed to ensure that the environment remained free of entrapment hazards due to large gaps in bed side rails for these 5 non-sampled residents.	F 323			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents who attended meals in the main dining room. Based on observation, interview and record review, the facility failed to ensure the safe and sanitary delivery food for 1 resident (#32) who required assistance with meals. The facility further failed to distribute, and store food in a safe and sanitary manner related to unsanitary handling of serving dishes and un-labeled, undated and expired food items in the facility kitchen for 1 of 4 days of the survey.	F 371			

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F 371	<p>Continued From page 12</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- During initial tour of the facility kitchen on 09/26/2016 at 8:26 AM observation revealed the following: 3 yogurts in the refrigerator with expiration dates of 9/22/16, 9/16/16 and 9/12/16.</li> </ul> <p>09/26/2016 8:33:09 AM walk in fridge temp 35, one un-labeled, undated, pitcher of milk shake, 12 yogurts all dated 9/21/16, one bottle of juice and one bottle of milk shake and one sandwich on a ready-to serve cart , all un-labeled and undated</p> <p>Interview on 9/26/2016 at 8:59AM dietary staff O stated, "We check the expiration dates every 4 days, we checked the food dates, if it's after 4 days, we toss them. The milk shakes or juice bottles or pitchers should be dated when prepared, even if it is made this morning. The ready to go cart is for the snack at 10a today " .</p> <p>Interviewed on 09/26/2016 2:20:41 PM dietary staff N confirmed the expired yogurt was thrown away and stated the drinks and food should be dated and labeled as they are made. The bowl of butter was for employees, but they should wipe it down and cover the butter anyway and they should have put the lid back on the milk when done with each serving.</p> <ul style="list-style-type: none"> <li>- Observation of meal service on 09/26/2016 11:56 AM revealed dietary staff - M using gloved hands removed a paper covering on a recessed serving cart with ice cream. The dietary staff member picked up a bowl for ice cream, scooped it and served a resident, then placed his/her gloved hands on a table and wheelchair and</li> </ul>	F 371			

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F 371	<p>Continued From page 13</p> <p>returned to the serving cart and grasp another bowl for serving without changing gloves and/or washing his/her hands.</p> <p>Interviewed on 9/26/16 at 11:57 A.M. with dietary staff M included he/she did not respond to identify when should he/she wash hands, went to the facility kitchen, changed his/her gloves and continued serving resident's.</p> <p>Observation on 09/26/2016 12:11 PM revealed a uncovered bowl of butter on a table in the dining room, the lid was next to the bowl with a butter knife on it and bread crust in the butter.</p> <p>The undated facility Food Service policy documented that all food must be labeled with the name of the item and the date the item was prepared and /or opened. Food items that have expiration dates shall be disposed of no later than the expiration date. Also all staff handling ready to eat items shall wear single serve gloves.</p> <p>The facility failed to serve, distribute and share food in a sanitary manner for residents in the facility.</p> <p>- Observation on 09/28/2016 at 12:01 P.M. in the facility's main dining room, revealed resident #32, a mobility impaired resident, was assisted to eat lunch. Direct care staff S seated to the resident's right, spoon fed the resident throughout the meal. Twice during the meal direct care staff S raised a spoonful of mashed potatoes to his/her own mouth before he/she placed the food in the resident's mouth.</p> <p>Interviewed on 09/28/2016 at 2:52 PM, direct care</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 14 staff S stated he/she often assisted the residents with feeding and would take a bite to check the foods temperature before placement in resident's mouth. Direct care staff S stated this was a long time practice of his/hers.  Interviewed on 09/28/2016 at 4:00:06 P.M. administrative licensed nursing staff C stated the expectation for checking food temperatures was to use a thermometer.  Interviewed on 9/29/16 at 1:30 P.M. administrative staff A acknowledged a need for re-education when staff assisted residents with meals.  The undated facility Food Service policy failed to provide guidelines for the checking of food temperatures by feeding assistants.  The facility failed to follow sanitary procedures and/or adhere to infection control practices when direct care staff member S taste/temperature tested a disabled resident's meal and used the same contaminated utensil to feed the resident.	F 371			
F 499 SS=F	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS  The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.  Professional staff must be licensed, certified, or registered in accordance with applicable State laws.  This REQUIREMENT is not met as evidenced	F 499			

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F 499	Continued From page 15 by: The facility identified a census of 46 residents. Based on record review and interview, the facility failed to employ professional staff who were licensed, certified or registered in accordance with State laws when 1 of 7 medication aides' certification expired and he/she distributed medications for 3 sampled residents (#1, #7, and #12) intermittently over a 3 month period. Findings included: - On 9/28/16 at 9:45 A.M. record review of employee files revealed, the facility employed 7 (full and part-time) Certified Medication Aides. A review of the medication aides' certifications revealed direct care staff member S certification expired on 9/25/15 and renewal with the Kansas State Board of Licensure on 1/26/16. Review of the facility working schedule from September 2015 to January 2016 revealed this same staff member administered medications to at least three sampled residents (#1,#3, and #12) for day and evening shifts for a total of 313 doses over a 4 month period while his/her medication certification was expired. There was no evidence of medication errors during this time period. On 9/29/16 at 1:00 P.M. administrative staff A stated the facility did not have a policy related to the routine examination of staff certifications. On 9/28/16 at 4:25 P.M. interview with administrative licensed nurse D stated the Medication Aide CMA S, during the above mentioned 4 month period, did work full time at the facility and had decreased to part time. Administrative staff A and administrative licensed nurse D both stated they were unaware staff member S certification had lapsed and he/she passed medications during that time. Administrative staff A stated he/she would report the instance and conduct an investigation.	F 499			

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F 499	Continued From page 16 Administrative staff A stated the computer would normally flag staff members whose license/certification was up for renewal. The facility failed to ensure that residents were provided medications by professionally registered and/or certified staff during this 3 month period.	F 499		