

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

PRINTED: 07/19/2016  
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>C</b> <b>07/18/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ATCHISON SENIOR VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1419 N 6TH STREET</b> <b>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 225 SS=D	<p>The following citations represent the findings of complaint investigation #102565 and #102615.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the</p>	F 225			

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 225	<p>Continued From page 1</p> <p>incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample was 5 residents. Based on record review and interview, the facility failed to report resident #1's fall with a fracture (broken bone) to the State survey agency.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Review of the Physician's Order Sheet in the closed record for resident #1, signed 6/2/16, included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).</li> </ul> <p>The Quarterly Minimum Data Set (MDS) dated 6/12/16 noted a Brief Interview for Mental Status (BIMS) of 10 (8 to 12 indicated moderately impaired cognition). The resident required supervision with transfers, and was steady at all times with transfers. He/she experienced one non-injury fall since the last assessment.</p> <p>The Significant Change MDS dated 12/15/15 documented a BIMS of 15 (greater than 13 indicated intact cognition). The resident required supervision with transfers, and was steady at all times with transfers. He/she experienced one fall since the last assessment.</p> <p>The Care Area Assessments (CAAs) dated</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>12/15/15 revealed the resident had pneumonia (inflammation of the lungs) and staff expected him/her to return to the previous level of functioning.</p> <p>The care plan dated 6/10/16 directed staff to encourage the resident to participate to the fullest extent possible with each interaction and to use the bell to call for assistance. Staff ensured he/she wore appropriate footwear.</p> <p>The care plan updated on 7/1/16 reflected the resident required the assistance to two staff for transfers.</p> <p>The fall investigation report dated 6/22/16 noted the resident's roommate went to the nurse's station and stated the resident had fallen.</p> <p>The right hip x-ray performed at the hospital revealed a fracture of the right femoral head (the top of the bone in the thigh).</p> <p>On 7/14/16 at 12:00 PM, Administrative staff A stated this incident was not reported to the State survey agency, because the resident's roommate explained what had happened. He/She was not aware an incident like this needed to be reported.</p> <p>The facility's policy "Abuse, Neglect, Exploitation Policy", dated 2015, revealed it was the responsibility of the administrator to report the occurrence.</p> <p>The facility failed to report to the State survey agency this resident's fall with a fracture for this cognitively impaired resident.</p>	F 225			