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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>17G071</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>06/19/2013</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHESDA LUTHERAN COMMUNITIES INC/FAITH VILLAGE #2</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>14175 W 113TH STREET<br/>SHAWNEE MISSION, KS 66215</b> |
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| W 000 | INITIAL COMMENTS<br><br>The following deficiencies resulted from a fundamental survey (00XD11) conducted on 6/10/13, 6/11/13, 6/12/13, 6/13/13, 6/17/13, 6/18/13 and 6/19/13 at the above identified facility.  | W 000 |  |  |
| W 189 | 483.430(e)(1) STAFF TRAINING PROGRAM<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>The facility reported a census of 14 clients with 4 clients sampled.<br><br>Based on observation, interview and record review the facility failed to provide each employee with continuing training that enables the employees to perform his/her duties competently in areas of mealtimes (sampled client #130 and #150, and non-sampled client #110, #180, #200 and #210), and in the area of engagement in the day program activities (non-sampled # 210) to perform his/her duties with competency.<br><br>Findings included:<br><br>- At house, on 6/12/13 at 7:15 a.m., at breakfast, client # 130 is at the table eating breakfast with no napkins present. At 7:47 a.m. client #210 had toast and eggs, ate with his/her fingers with no napkin or drink present. Staff did not sit at table to assist client with eating or train on family style dining. Staff (C) did not prompt client #210 to use utensils or napkin. | W 189 |  |  |

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| 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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| W 189   | Continued From page 1<br><br>At the day program on 6/12/13 at 11:13 a.m., clients going to the gym for lunch. Clients asked to sit at the tables. Clients sat at the table waiting for lunch to be served. Client #120 sat at a long table by his/herself. At 11:33 a.m. clients were waiting for lunch. At 11:36 a.m. meal served by staff giving a plate of food to clients, with no training on family style dining. The meal included chips, pizza, cheese stick, canned fruit, and yogurt. There no napkins or drink at the table. Client #150 is eating chips rapidly, with no prompts, by staff, to slow his/her eating. At 11:39 a.m. there are still no napkin or drinks at the table. Client #130 meal brought to him/her with no silverware. Staff (D) said, "We don't all have spoons or napkins." At 11:14 a.m. client #150 is eating pizza with food falling to floor. Staff did not assist him/her to slow eating. At 11:48 a.m. napkins were brought out and placed on the table. There were no prompts by staff to assist the clients with napkin usage. Staff did not sit down at the table to assist clients with meal time. Client #150 continues to eat with his/her mouth full and spillage on floor.<br><br>At the house, on 6/12/13 at 5:00 p.m. staff (C) said, "Come get a plate of food from the counter." Food was served in divided plates for all clients without choices. Utensils and napkins were on the counter. At 5:04 p.m. staff (c) served lemonade and milk to drinks. Clients did not get to pour drinks as staff did it for them. Client #180 is offered milk, staff gave him/her a cup and then staff poured it for them. At 5:08 p.m. no staff at table, napkins now placed on the table. At 5:10 p.m. client #220 is offered to eat at the dining room table with no avail. Staff then attempted to | W 189   |   |                      |   |

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| W 189   | <p>Continued From page 2</p> <p>feed client in the living room, however the client did not eat it and pushed it away. Staff (E) assisted client #110 to sit up and eat his/her food. Client #200 has large amount of food in his/her mouth, with no assistance.</p> <p>Interview with staff (C), on 6/12/13 at 5:22 p.m. stated, " Yeah, I offer forks and or spoons. Sometimes on weekend we do a buffet "</p> <p>Interview with staff (F), on 6/13/13 at 2:20 p.m. stated, " I know we train them and then do for them, we need to work with clients to help at mealtime. "</p> <p>- At day program, on 6/12/13 at 10:10 a.m. observed clients in the day program. Located client #210 at 10:49 a.m. laying on the floor in the locker room/shower room in dark with his/her eyes closed, hand on side of head and other hand in his/her pants. Unable to locate staff observing client in the area. Staff (G) tried to get client up with lots of prompts, staff said client can lay on the therapy bed. Client was redirected to the day program into the sensory room.</p> <p>Review of client #210 ' s clinical record reviewed a diagnosis of severe mental retardation, autism, seizure disorder, impulse control disorder, ulcerative colitis and acne. Client was admitted to the facility on 9/23/02. Individual Program Plan dated 8/01/12 which outlines training to help actively engage client into teaching skills. Staff needs to ensure visual checks for client #210 for safety. At the house, client #210, is to be checked every 10 minutes in the back yard and 30 minutes indoors. Upon observation in the day program did not see staff checking client #210 on</p> | W 189   |   |                      |   |

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| W 189   | Continued From page 3<br>visual checks.<br>The individual program plan documents data for client #210 to complete daily program schedule of work boxes with verbal prompt started 4/23/13.<br>The program is revised as client #210 will hit his/her head so does not want to do the work boxes. Program data documents only four days of data since program developed.<br>Interview with staff (H), on 6/12/13 at 11:10 a.m., regarding laying back locker room, " Oh yes likes it there, he/she goes from locker area to sensory room and goes back and forth. "<br><br>Interview with staff (G), on 6/12/13 at 10:52 a.m. stated, " I know (he/she) does this in his room. " I informed staff that client is in bathroom locker room laying on the floor. Staff (G), then stated, " I am not aware of him/her doing that. "<br><br>The facility failed to demonstrate competency in areas of continuing training that enables the employees to perform his/her duties competently in areas of mealtimes, and engagement in the day program. Therefore, the facility needs to ensure staff competency to train clients on programs and daily living. | W 189   |   |                      |   |
| W 336   | 483.460(c)(3)(iii) NURSING SERVICES<br><br>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.<br><br>This STANDARD is not met as evidenced by:<br>The facility census equaled 14 clients with 4 clients sampled.   | W 336   |   |                      |   |

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| W 336   | <p>Continued From page 4</p> <p>By observation and interview for two sampled clients (#150 and #190), the facility nurses failed to complete quarterly examinations performed within the month in which the end of the quarter falls.</p> <p>Finding included:</p> <ul style="list-style-type: none"> <li>- Review of client #150 ' s clinical record reviewed a diagnosis of profound mental retardation, scoliosis, bipolar mood disorder, constipation, acne, allergies, esophageal reflux, insomnia, and diabetes. Client admitted to the facility on 12/09/94. Individual Program Plan dated 4/24/13 and continued on 5/03/13. By review of the quarterly nursing assessments documented two quarters met on 5/10/13 and 8/10/12. Other quarterly assessments were outside of the month the quarter falls in.</li> </ul> <p>Interview with nurse (A), on 6/17/13 at 4:37 p.m. stated, " Done with most current others I cannot state for them. "</p> <ul style="list-style-type: none"> <li>- Review of client #190 ' s clinical record reviewed a diagnosis of profound mental retardation, severe autism, seizure disorder, history of aggression, history of sleep disorder, and pica. Client admitted to the facility on 11/23/04. Individual program plan dated 11/09/12. By review of the quarterly nursing assessments documented two quarters met on 6/03/13 and 2/14/13. Other quarterly assessments were outside of the month the quarter falls in.</li> </ul> <p>Interview with nurse (A), on 6/17/13 at 4:37 p.m. stated, " Done with most current others I cannot</p> | W 336   |   |                      |   |

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| W 336   | Continued From page 5<br>state for them. "  | W 336   |   |                      |   |
| W 381   | <p>The facility nurses on a quarterly basis, failed to complete quarterly examinations performed within the month where the quarter falls. Therefore the facility needs to complete quarterlies timely to ensure good health.</p> <p>483.460(I)(1) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must store drugs under proper conditions of security.</p> <p>This STANDARD is not met as evidenced by:<br/>The facility census equaled 14 clients with 4 clients sampled.</p> <p>Based on observation, staff interview, and record review the facility failed for three of twelve clients receiving medications (non-sample client #160, #220, and #230) to store drugs under proper conditions of security by leaving medications in clients rooms unsecured during the medication pass.</p> <p>Findings include:</p> <p>- Upon observation on 6/11/13 at 3:54 p.m., in the client ' s #220 ' s bedroom, revealed nurse (B) entering the client ' s bedroom as he/she put the medications on the client ' s bookshelf. The nurse then stated that he/she needed to go get another staff to assist with the medication pass as client was displaying behaviors. When the nurse left the room the medications remained on the bookshelf in the bedroom unsecured with client #220.</p> | W 381   |   |                      |   |

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| W 381   | <p>Continued From page 6</p> <p>Review of client #220 's clinical record reviewed a diagnosis of profound mental retardation, idiopathic epileptic seizure disorder, gastrostomy tube, pervasive development disorder, autism spectrum, hypothyroidism, bipolar disorder, aggression, constipation, and Lennox-Gastaut syndrome. Client #220 admitted to the facility on 4/03/07.</p> <p>Review of client #220's medication revealed: vimpat, lithium, onfi, trileptal, potassium, and Neurontin. Review of individual program plan dated 3/01/13 stated client #220 needs assistance with medication administration.</p> <p>- Upon observation on 6/11/13 at 4:52 p.m., in the client ' s #230 ' s bedroom, revealed nurse (B) entering the client ' s bedroom as he/she put the medications on the client ' s rolling desk tray beside the bed which the client is sitting on. The client #230 told the nurse needed yogurt. The nurse then stated that he/she will go get the yogurt. When the nurse left the room the medications remained on the desk tray beside client #230 unsecured.</p> <p>Review of client #230 ' s clinical record reviewed a diagnosis of moderate mental retardation, downs syndrome, celiac anemia, hypothyroidism, goiter, dysphagia, pseydophobia highastingnitisim, alopecia, allergic rhinitis, and depression. Client #230 admitted to the facility on 9/20/10.</p> <p>Review of client #230's medication revealed: celexa, breeze juice and artificial tears. Review of individual program plan dated 10/16/12 stated client #230 needs assistance with medication</p> | W 381   |   |                      |   |

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| W 381   | <p>Continued From page 7 administration.</p> <p>- Upon observation on 6/11/13 at 5:23 p.m., in the client ' s #160 ' s bedroom, revealed nurse (B) entering the client ' s bedroom as he/she put the medications on the client ' s dresser. The nurse then stated that he/she needed to go get another staff to assist with the medication pass. When the nurse left the room the medications were left in the bedroom unsecured with client #160.</p> <p>Review of client #160 ' s clinical record reviewed a diagnosis of profound mental retardation, tracheostomy, congestion, constipation, occasional diarrhea, chronic pneumonia, dislocated right hip and left hip subluxed, and dysphagia. Client #160 admitted to the facility on 6/15/99.</p> <p>Review of client #160's medication revealed: baclofen, desmopressin, docusate sodium, gabapentin, Robitussin syrup, Reglan syrup, senokot syrup, water bolus, resource bolus, albuterol, and ipratropium. Review of individual program plan dated 2/07/13 stated client #160 needs assistance with medication administration.</p> <p>Interview with nurse (B), at 5:57 p.m. stated, " I will do better with the medications. "</p> <p>The facility failed to store drugs under proper conditions of security for clients #160, #220, and #230. Potential outcome is the clients may be harmed by medications when unsecured.</p> | W 381   |   |                      |   |