STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	175557		06/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

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F 000	INITIAL COMMENTS	F 000		
	The following citations represent the findings of a Health Resurvey and Complaint Investigations #KS00100794, #KS00097215, #KS00096754, #KS00096677, #KS00096583, #KS00093714, and #KS00091811.			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	This REQUIREMENT is not met as evidenced by: The facility identified a census of 65 residents. Based on observation, interview, and record review, the facility failed to promote care for residents in a manner that maintained or enhanced each resident's dignity, in 1 of 3 dining rooms on 2 of 5 days of the survey.			
	Findings included:			
	- During an observation on 5/19/16 at 5:48 P.M. licensed staff H and direct care staff O stood to feed residents dinner.			
	During an observation on 05/24/2016 at 12:33 P.M. licensed staff I stood to feed residents lunch.			
	During an interview on 5/19/16 at 6:00 P.M. direct care staff O stated he/she did not normally stand to feed residents; he/she did just for today.			
	During an interview on 05/19/2016 at 6:14 P.M.			

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 241	Continued From page 1 licensed staff H stated the staff did normally stand beside residents to assist during mealtimes because there were several residents to feed and staff had to roam around to assist them. During an interview on 05/25/2016 at 12:57 P.M. licensed staff I stated two staff members normally assisted residents during mealtimes. He/she stated when only two staff were present during mealtimes the staff had to move around frequently to assist with feeding and were not able to sit down. During an interview on 5/26/16 at 5:59 P.M. administrative staff A stated he/she expected staff not to stand to assist residents with eating during mealtimes. The "Meal Service, Dining Room" policy dated 11/30/14 and the "Feeding Resident Requiring Total Assist" policy dated 11/30/14 lacked direction to staff to be seated beside residents to assist with feeding during mealtimes. The facility failed to provide an environment that promoted dignity to residents during mealtimes.	F 241		
F 323 SS=D	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.	F 323		

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: The facility reported a census of 65 residents and the sample included 22 residents. Based on observation, interview, and record review the facility failed to monitor a physician ordered Wanderguard bracelet (protective device to alert staff of a residents attempt to elope) for 1 of 5 sampled residents (#80) with such devices. Findings included: - Resident #80's physician order sheet dated 12/11/15 documented the resident had a diagnoses of dementia (a progressive brain disorder characterized by failed memory and confusion). The admission Minimum Data Set (MDS) dated 12/18/15 revealed a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The resident was independent with activities of daily living (ADLs) and did not refuse cares. Review of the Falls Care Area Assessment (CAA) dated 12/18/15 documented the resident was at risk for falls due to an unsteady gait and anti-depressant medication use (medication used to relieve feelings of sadness). Review of the quarterly MDS dated 3/19/16 documented a BIMS score of 11, which indicated moderate cognitive impairment. The resident required supervision with ADL's and experienced verbal behaviors toward others and refused cares for 1-3 days during the observation period. Review of the 12/11/15 Wanderguard	F 323		

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F 323	Continued From page 3 assessment revealed the resident was a high risk for elopement. Review of an elopement risk evaluation dated 12/11/15 documented the resident lacked the ability to exit the facility. The 12/18/15 and 3/14/16 quarterly assessments revealed the resident was at risk for elopement. Review of the resident's care plan dated 3/7/16 documented the resident frequently wanted to leave, packed his/her bags, and was exit seeking. The care plan directed staff to redirect the resident from doors and exits as needed, observe him/her for exit seeking behaviors by using diversion, ensure the resident had a personal wander prevention device (Wanderguard), check the Wanderguard bracelet function daily, recheck exit door alarms daily, and administer medications as ordered. Review of the physician's order sheet dated 12/11/15 directed staff to check the resident's Wanderguard placement every shift and check the Wanderguard function at bedtime (hour of sleep) between 11:00 P.M. and 7:00 A.M. Review of the Treatment Administration Record (TAR) documented a review of the Wanderguard function from 12/11/15 through 4/9/16. The document lacked further documentation the resident's Wanderguard function and placement were checked on the bedtime shift after 4/9/16 through 5/26/16. During an observation on 5/19/16 at 2:01 P.M. the resident was alert, tearful.,and walked with licensed staff K.	F 323		

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F 323	Continued From page 4 During an observation on 5/23/16 at 4:05 P.M. the resident stood at the nurse's station in tears. During an interview on 5/19/16 at 2:05 P.M. the resident expressed he/she wanted to leave and "had to get out of here," because the "teacher was punishing" him/her and he/she was unsure why he/she "had to go through this". During an interview on 5/19/16 at 5:42 P.M. direct care staff Q said the resident tried to get out of the building all the time,stood by the door frequently, and tried to leave at least monthly. He/she said the resident wore a Wanderguard. He/she worked the night shift when the resident's exit seeking behavior increased. During an interview on 5/19/16 at 5:48 P.M. direct care staff P said the resident was frequently agitated, stood near the exits, and never got out of the facility. During an interview on 5/19/16 at 5:56 P.M. direct care staff R said the resident wore a Wanderguard, was frequently agitated/cried and he/she reported these behaviors to the nurse. During an interview on 5/19/16 at 5:59 P.M. direct care staff S said the resident wore a Wanderguard on his/her left ankle and he/she reported behaviors to the nurse if they occurred during their shift. During an interview on 5/19/16 at 1:56 P.M. licensed staff M stated the resident wore a Wanderguard and was frequently exit seeking. He/she said the resident's Wanderguard placement was checked every shift.	F 323		

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F 323	Continued From page 5 During an interview on 5/19/16 at 2:31 P.M. licensed staff L stated the sliding doors downstairs to the outside alarmed if the fire alarm was on and the code was entered. He/she said the Wanderguard placement on resident #80 was checked on his/her night shift. During an interview on 5/19/16 at 3:01 P.M. licensed staff K stated the elevator did not require a code, but the facility had a Wanderguard system. During an interview on 5/19/16 at 3:08 P.M. licensed staff N acknowledged the residents TAR lacked documentation the staff checked the resident's Wanderguard for working condition (function) from 4/9/16 through 5/26/16. Nurse N stated the night shift should record this. During an interview on 5/25/16 at 12:18 P.M. administrative staff D stated there was a pharmacy documentation error on the TAR and was unsure why staff did not record the check for Wanderguard function. Administrative nursing staff D stated staff may have thought their signature for placement covered a check of function for the Wanderguard as well. Review of the Elopement Risk policy dated 11/30/14 documented staff completed an elopement risk assessment on admission and quarterly and residents identified as an elopement risk had individualized interventions implemented with care plan documentation and electronic monitoring devices, such as Wanderguards were checked daily for placement and function. The facility failed to monitor the function of a	F 323		

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F 323	Continued From page 6 physician ordered Wanderguard for this cognitively impaired resident with a history of wandering.	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 65 residents with a sample of 22 residents. Based on observation, interview, and record review the facility failed to date and label opened food products and failed to provide a sanitary cooking environment in one main kitchen for one of five days. Findings included: - During an observation on 5/19/16 at 1:06 P.M. the facility's kitchen had one box of dry rice, a bag of sugar, two bags of noodles, a tub of cheerios, a box of fish, and hard boiled eggs that had been opened and not dated. The kitchen also had an expired box of prune juice cans with a use by date of 3/24/16. During an observation on 5/25/16 at 11:02 A.M.	F 371		

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F 371	Continued From page 7 dietary staff EE had a beard and prepared food with no beard guard in place. During an interview on 5/19/16 at 1:06 P.M. dietary staff DD stated food was to be dated when opened. During an interview on 5/25/16 at 11:31 A.M. dietary staff DD stated the staff had beard guards available, but he/she did not expect staff with short facial hair to wear. During an interview on 5/26/16 at 5:59 P.M. administrative staff A stated he/she expected dietary staff with beards wore beard guards when in the kitchen. The facility provided "Food and Supply Storage" policy dated 11/30/14 documented food and supplies were stored under sanitary and secured conditions, according to approved State and Federal standards, to retain quality of products. Food supplies must be dated as required by state regulations. The facility provided "Dress Code/Uniforms" policy dated 11/30/14 documented individuals with any length of facial hair must wear a guard with complete coverage (mustache and beard). The facility failed to store, prepare, distribute and serve food under sanitary conditions when the facility failed to date opened food products and ensure staff covered facial hair when in the kitchen.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	F 406		

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F 406	Continued From page 8 If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: The facility identified a census of 65 residents. The sample included 22 residents. Based on observation, record review, and interview the facility failed to obtain a Level II determination for required specialized rehabilitative services for 1 of 1 resident (#5) reviewed for specialized rehabilitative services. Findings included: - Review of resident #5's clinical record revealed he/she admitted to the facility on 12/10/15 with diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), anxiety disorder (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), and mild intellectual disabilities (a disability that occurred in the developmental period and is characterized by sub-average intellectual functioning).	F 406		

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F 406	Continued From page 9 Review of the admission minimum data set (MDS) dated 2/26/16 revealed the resident had a brief interview for mental status (BIMS) score of 15 which indicated intact cognition. The assessment indicated the resident did not have a Preadmission Screening and Resident Review (PASRR) (a federal requirement to help ensure that individuals were not inappropriately placed in nursing homes for long term care) and he/she had not been evaluated by a Level II PASRR assessor. The care area assessments (CAA) for cognitive loss/dementia and psychosocial well-being dated 2/26/16 indicated the resident occasionally raised his/her voice at staff and had accusatory behaviors. The CAA for behavioral symptoms dated 2/26/16 indicated the resident occasionally rejected cares. The care plan dated 3/3/16 indicated the resident occasionally raised his/her voice to staff and directed staff to administer psychiatric medication as ordered, refer him/her to psychiatric services as indicated and refer to social work for follow-up. The Certificate of Care Assessment dated 11/2/15 indicated the resident required further evaluation and had been referred to a Level II assessor. Interview on 5/24/16 at 4:33 P.M. with resident #5 stated he/she wanted to live in his/her group home and waited on an approval to return. Interview on 5/25/16 at 11:40 A.M. with social service staff B stated he/she was not familiar with	F 406		

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F 406	Continued From page 10 PASRR and did not know about the status of the Level II assessor. Staff B stated the resident wanted to return to his/her group home. Interview on 5/25/16 4:34 P.M. with administrative staff A stated the resident had previously lived in a group home and wanted to return to the group home. Administrative staff A stated the resident arrived to the facility on 12/10/15 with a Level 1 CARE assessment certificate that indicated he/she should be referred to a Level II assessor and stated to his/her knowledge, the resident did not qualify for a Level II PASRR, but he/she would clarify with the Kansas Department of Aging and Disability Services (KDADS). Review of written communication from a Care Program Manager dated 6/1/16 at 8:16 A.M. documented a level II PASRR was completed on 11/17/15 and the resident's determination was MR3T-9 months (meant the resident with mental retardation could remain in the nursing home for 9 more months) with recommended services. The determination was good until 8/17/16. The facility provided policy Mental Illness/Mental Retardation dated 11/30/2014 indicated the facility's Director of Social Work obtained the appropriate Level I and/or Level II screenings. The facility failed to timely obtain the Level II determination for required specialized rehabilitative services as indicated on the resident's Certificate of Care Assessment.	F 406		