STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008011	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA FALLS ASSISTED LIVING	408 E CENTRAL PO BOX 906 ANDOVER, KS 67002

(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
S 000	INITIAL COMMENTS The following represent the findings of a resurvey with attached complaints for the above named Assisted Living facility conducted 07/11/22, 07/12/22, 07/13/22, 07/14/22 and 07/18/22.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (B) The facility reported a census of 77 residents. The sample included nine residents (R) and six closed record reviews. Based on observation, interview, and record review the administrator failed to ensure the facility staff assessed, acknowledged and placed interventions for R 111 when she exhibited a change of condition of mental status which included episodes of R 111 exiting the facility without facility staff knowledge. This included performing an elopement risk assessment, which identified specific language barriers/and risk which were not addressed on R 111's "Functional Capacity Screen" (FCS),	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3026	Continued From page 1	S3026		

"Negotiated Service Agreement" (NSA), or the "Healthcare Service Plan" (HSP). This allowed the resident to leave the facility without the facility staff knowledge placing the resident at risk for injury and harm.

Findings Included:

- Record review for R111 on 07/11/22 revealed an admission date of 07/16/21 with diagnoses of abnormal coagulation profile, anxiety disorder, and frequency of micturition.

Record review of the "FCS" dated 07/20/21 identified R111 required physical assistance with bathing, dressing, and management of medications. The resident had intact cognition, was understandable and understood others. She was independent with walking and mobility and used a cane.

Record review of the "NSA" dated 07/20/21 identified the following healthcare services provided by the facility; physical assist with showers three times a week, facility would manage the resident medications and treatments, staff were to assist as needed with mobility/walking, and the resident was independent with a cane. Her cognitive status was intact and there were no communication barriers identified on the assessment.

Record review of the "HSP" dated 07/20/21 instructed staff to assist with bathing three times a week, administer medications, noted she was independent with a cane, and alert and orientated to person, place and time.

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S3026	Continued From page 2 Record review of the "Electronic Progress Notes" dated 08/11/21 thru 07/13/21 revealed the following entries: On 08/11/21 at 05:36 PM and signed by Director of Operations D revealed; - ...Vietnamese as the resident's 1st language but noted she could make her needs known without the assistance of an interpreter for most things. The facility did have a Vietnamese interpreter they could have come out when needed. On 10/08/21 at 10:05 AM and signed by Licensed Nurse (LN) C revealed the facility gave the resident's Durable Power of Attorney (DPOA)a list of medications that the resident was on. The DPOA also requested a Montreal Cognitive Assessment (MoCA) test for her mother to stage her dementia. On 03/08/2022 the resident's physician ordered an antianxiety medication for the resident. On 05/06/22 at 12:06 PM LN B -documented the resident's family called the facility on 05/05/22 concerned that the resident appeared to be more confused and family wanted the doctor to assess for dementia. On 05/10/22 at 12:29 PM revealed the resident was seen by Advanced Practice Registered Nurse (APRN) F for family concerns of possible dementia. APRN F recommended the facility set up a MOCA screening when the family could be there to interpret due to the language barrier. On 05/16/22 at 03:39 PM documented the resident was seen by APRN G due to the family	S3026		

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S3026	Continued From page 3 concerns of possible dementia and requested a MoCA test to be done. Family came in to be the interpreter for this visit. MoCA was performed and the resident would be reassessed after medication changes to determine if it was dementia or depression that she presented with. The resident received orders for Zoloft (antidepressant medication) 50 milligrams (mg) daily and to discontinue Trazadone (antidepressant medication). The resident stated she did feel a little depressed and agreed to medication changes. Orders were processed and sent to pharmacy. On 05/17/22 at 09:30 AM (Late Entry) LN B documented she spotted the resident walking down Andover Road (busy 4 lane road that runs through town) on her way into work. LN B turned around and found the resident in one of the businesses, talking to the staff, and LN B offered her a ride home. The resident agreed and was assisted back to the facility and into her room. The resident was known for going outside and returning to the facility on her own. Last week the resident was at Walgreens and told the store staff she needed help getting home and was able to tell them where she lived and what her room number was. Andover police department called this facility to alert staff that she needed assistance back to the facility. LN B then went and picked the resident up and brought her back to the facility. The resident's NSA, FCS, and/or HSP lacked any updates after the resident left the facility, unsupervised twice and required assistance to return to the facility.	S3026		

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S3026	Continued From page 4 The resident record lacked any elopement assessment prior to 05/19/22. Elopement risk assessment performed by the facility on 05/19/22 revealed the following: 1. The resident had wandering behaviors. 2. The resident had wandering behaviors, which placed the resident at risk of getting to a potentially dangerous place. 3. The resident was cognitively impaired with poor decision-making skills. 4. The resident had visual, auditory, or communication deficits. 5. The resident spoke little English and had a language barrier at times. 6. The resident was known to go outside and return on her own. 7. The resident went to store once and needed assist back but was able to state address. The "Electronic Record" lacked an updated FCS, NSA and HSP identifying the change of mental status, communication barrier, wandering, independent without mobility device and decision making. On 07/11/22 at 01:22 PM revealed staff reported the resident was walking around outside on 07/06/22 and noted they were concerned due to the heat. Staff contacted the resident's DPOA/daughter about these concerns and she stated, "I think if my mom wants to walk around, it'll be ok". Record review of the local weather for 07/06/22 on the Weather Channel web page weather.com revealed the temperature that day of 100 degrees Fahrenheit.	S3026		

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S3026	Continued From page 5 On 07/11/22 at 8:01 PM LN B documented the Resident was moved to a different apartment with DPOA approval for resident safety and to reduce the risk of resident being exposed to extreme weather, unsupervised. The resident had a history of leaving the facility, going on long walks, and needing assistance getting back to the facility. Staff would continue to monitor and report any wandering behavior and would complete hourly checks for the first 72 hours of room change. Staff would encourage and redirect the resident to the courtyard when resident wanted to go outside. Review of the resident's sign out log dated 04/24/22 to 07/11/22 lacked any entry for R111 leaving or returning to the facility. Observation on 7/11/2022 at approximately 01:45 PM of R 111 walking on the inside of the building in front of the front doors of the building. Interview on 07/11/2022 at approximately 1:45 PM with resident R 111 resident did answer yes to most questions and used extensive hand gestures. Interview on 7/11/2022 at approximately 05:30 PM with resident R 111 did answer one-word answers appropriately when identifying the individuals in photographs in her room. Interview on 07/11/22 with Administrator H and LN B confirmed the FCS was marked with no cognitive impairment, no communication deficit, and no impaired decision making. The elopement assessment was reviewed and identified the FCS	S3026		

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S3026	Continued From page 6 did not match the elopement assessment. The NSA and HSP did not identify the changes captured in the elopement assessment. LN B stated last week the facility placed a keypad lock on the resident room door that opened to the parking lot to deter the resident from leaving the facility without staff knowledge. LN B confirmed the NSA and HSP lacked the documentation and interventions for the R 111 to keep her safe. The administrator failed to ensure the facility staff assessed, acknowledged, and placed interventions for R111 when she exhibited a change of condition of mental status, which included episodes of R111 exiting the facility without staff knowledge. This included performing an elopement risk assessment, which identified specific language barriers/and risk which were not addressed on R111's "Functional Capacity Screen" (FCS), "Negotiated Service Agreement" (NSA), or the "Healthcare Service Plan" (HSP). This allowed the resident to leave the facility without the facility staff knowledge placing the resident at risk for injury and harm and violating her resident rights by not addressing the language barrier and concern of change of cognition with interventions in place to assist the resident in being successful in walking in a safe place.	S3026		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family	S3175		

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S3175	Continued From page 7 member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (b) The facility reported a census of 77 residents. The sample included 9 residents (R) and 6 closed record reviews. Based on observation, interview and record review the administrator failed to ensure the licensed nurse identified each medication the resident would self-administer on the negotiated service agreement for R 113 and R 115. Findings included - - Record review for resident 113 revealed an admission date of 08/29/13 with diagnoses of rheumatoid arthritis, impulse disorder, anxiety disorder and type 2 diabetes. Record review 07/13/22 of the functional capacity screen dated 07/15/21 identified the resident required physical assistance with	S3175		

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S3175	Continued From page 8 bathing, dressing and she lacked the ability to manage her own medications and treatments. Record review 07/13/22 of the negotiated service agreement dated 07/15/21 identified the facility would manage the medications and treatments. Record review 07/13/22 of the healthcare service plan instructed staff to administer medications and simple treatments, home health would manage weekly injections. Record review 07/14/22 of the signed physician orders revealed the following orders; Muscle rub three times daily to right knee - resident may self-administer Accu checks as needed - resident may keep her glucose meter and her room and check her own blood sugars as needed. Record review 07/14/22 of the facility document titled Self Administration of Medications Assessment Assisted Living Facility dated 05/04/21 revealed the following typed entry in the medications approved section "resident may self med all lotions and creams and proair HFA (respiratory medication), and voltaren gel (pain medication)", and typed into the comments section was the following ; ...staff to administer medications and perform simple treatments except for medications approved due to history of noncompliance. - Record review for R 115 revealed an admission date of 07/0/19 with diagnoses of major depressive disorder recurrent without psychotic features, unspecified dementia without	S3175		

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S3175	Continued From page 9 behavioral disturbance, essential primary hypertension, insomnia, type 2 diabetes mellitus without complications. Record review of the functional capacity screen dated 03/28/22 identified the resident to be independent with all activities of daily living, she lacked the ability to manage her own medications, and had impaired short-term memory. Record review of the negotiated service agreement dated 03/31/22 identified the following services provided by the facility; medication management and resident identified to have Melatonin (sleep aid) at bedside to be self-administered. Record review of the facility document titled Self Administration of Medications Assessment Assisted Living Facility dated 03/31/22 revealed the following entry typed in to the medications approved section - "Melatonin approved to be at bedside and self-administered". Record review of the signed physician orders revealed the following orders written and signed on 01/05/22; Flonase (respiratory medication) 1 actuated bilateral nares daily Claritin (allergy medication) 10 milligrams by mouth everyday as needed Saline nasal spray as needed May have Amitriptyline (nerve pain medication) at bedside for self-administration Observation on 7/12/22 at 11:04 AM revealed the following observation in the resident bathroom; 1	S3175		

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S3175	Continued From page 10 bottle of Flonase sitting on the left edge of the sink on the counter. The administrator failed to ensure the licensed nurse identified each medication the resident would self-administer on the negotiated service agreement for R 113 and R115.	S3175		
S3177 SS=D	26-41-205 (a) (2) Self Administration Assessment Content (2) Each assessment shall include an evaluation of the resident ' s physical, cognitive, and functional ability to safely and accurately self-administer and manage medications independently or by using a prefilled medication container or prefilled syringe. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (a)(2) The facility reported a census of 77 residents. The sample included 9 residents (R) and 6 closed record reviews. Based on record review and interview the administrator failed to ensure the licensed nurse performed an assessment for R 111 to determine that the resident could safely perform the self-injection of insulin and the administrator failed to ensure an assessment was performed annually for R 113 to determine the resident continued to be able to self administer selected medications safely.	S3177		

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S3177	Continued From page 11 Findings included: - Record review on 07/12/22 revealed an admission date of 07/16/21 with diagnoses of other general signs and symptoms, abnormal coagulation, anxiety disorder, and diabetes. Record review on 07/12/22 of the functional capacity screen dated 07/20/21 identified the resident required physical assistance with bathing, dressing, and she lacked the ability to managing her own medications and treatments. Record review 07/12/22 of the negotiated service agreement dated 07/20/21 indicated staff to dial up insulin pen and resident would self-inject insulin. Record review 07/12/22 of the health care service plan instructed staff to administer medications and perform simple treatments. The health care service plan lacked instruction to staff that the resident would self-inject her insulin. Interview on 07/12/22 at 09:46 AM with certified medication aide A revealed she dials the resident's insulin pens and the residents self-inject the insulin. Interview on 07/12/22 with Licensed nurse B confirmed the resident self-administration of medication assessment lacked an assessment of the resident ability to safely self-administer her insulin. The administrator failed to ensure the licensed nurse performed an assessment for R 111 to	S3177		

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S3177	Continued From page 12 determine that the resident could safely perform the self-injection of insulin. - Record review for resident 113 revealed an admission date of 08/29/13 with diagnoses of rheumatoid arthritis, impulse disorder, anxiety disorder and type 2 diabetes. Record review 07/13/22 of the functional capacity screen dated 07/15/21 identified the resident required physical assistance with bathing, dressing and she lacked the ability to manage her own medications and treatments. Record review 07/13/2022 of the negotiated service agreement dated 07/15/21 identified the facility would manage the medications and treatments. Record review 07/13/22 of the healthcare service plan instructed staff to administer medications and simple treatments, home health would manage weekly injections. Record review 07/14/22 of the signed physician orders revealed the following orders; Muscle rub (medication for pain) three times daily to right knee - resident may self-administer Accu checks (treatment for diabetes) as needed - resident may keep her glucose meter in her room and check her own blood sugars as needed. Record review 07/14/22 of the facility Self Administration of Medications Assessment Assisted Living Facility dated 05/04/21 revealed the following typed entry in the medications	S3177		

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S3177	Continued From page 13 approved section "resident may self med all lotions and creams and proair HFA (respiratory medication), and voltaren gel (pain medication)", and typed into the comments section was the following ; ...staff to administer medications and perform simple treatments except for medications approved due to history of non compliance. The administrator failed to ensure the licensed nurse performed an assessment for R 111 to determine that the resident could safely perform the self-injection of insulin and the administrator failed to ensure an assessment was performed annually for R 113 to determine the resident continued to be able to self administer selected medications safely.	S3177		