

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2022
NAME OF PROVIDER OR SUPPLIER AVENUE 81		STREET ADDRESS, CITY, STATE, ZIP CODE 8055 METCALF AVE OVERLAND PARK, KS 66204		
(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 citations represent the findings of an abbreviated survey for complaints #KS00171453 and #KS00171386 of the above named facility conducted on 05/2522-05/26/22.	S 000		
S 190 SS=D	26-39-102 (e) Admission, Transfer, Discharge (e) Before a resident is transferred or discharged involuntarily, the administrator or operator, or the designee, shall perform the following: (1) Notify the resident, the resident ' s legal representative, and if known, a designated family member of the transfer or discharge and the reasons; and (2) record the reason for the transfer or discharge under any of the circumstances specified in paragraphs (d) (1) through (4) in the resident ' s clinical record, which shall be substantiated as follows: (A) The resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the adult care home; (B) the resident's physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the adult care home; and (C) a physician shall document the rationale for transfer or discharge in the resident ' s clinical record if the transfer or discharge is necessary because the health or safety of other individuals in the adult care home is endangered.	S 190		

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

TITLE

(X6) DATE

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S 190	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-39-102(e)(2)(A)(C) The facility reported a census of 27 residents with two residents (R) and one closed record review included in the sample. Based on record review and interview the administrator failed to document in the resident's clinical record the reason for the involuntary discharge, the reason for the involuntary discharge substantiated by the resident's physician, the rationale of the transfer from the facility for not being able to meet the resident's needs, and the necessity of the transfer for the health and safety of the other residents in the care home. Findings included: - Record review for R525 revealed an admission date of 01/05/2022 with diagnoses of unspecified dementia with behavioral disturbance. Review of the admission "Functional Capacity Screen" (FCS) dated 2/14/2022 identified the resident with impaired short term, long term, memory recall and decision making. He required physical assistance with bathing, dressing and toileting. He was independent with transferring and mobility. He was incontinent of bladder and marked with wandering and inappropriate behaviors. Review of the admission "Negotiated Service Agreement" (NSA) dated 2/14/2022 identified the facility staff would assist with bathing and dressing. Instructed staff to check resident for incontinence and change the resident every 2 hours. The facility staff were to "remove from	S 190		

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S 190	Continued From page 2 situations if becomes agitated, may grab or pull at staff during cares, staff to stop and give time to calm and forget, try another staff member." Review of the nursing progress notes revealed the following entries: 01/06/22 at 09:00 PM by Administrative Nurse C -" ...certified medication aide (CMA) reports that ...is spitting on the floors, kicking doors that he can't open and setting off alarms. He is noted to be exit seeking ...Currently requiring 1:1 (one on one) while awake for safety and behaviors." 01/07/22 at 12:40 AM by Administrative Nurse C -" ...CMA reports ...removed all his clothing and bedding ...attempted to encourage him to go back to bed. He refused but is noted to be extremely restless ...attempted to check brief but was unsuccessful as he was increasingly agitated." 01/07/22 at 10:50 PM by Administrative Nurse C -"CMA reports that ...had barricaded himself into his apartment ...after gaining entry it was noted that he urinated on his T.V. (television), and Alexa. 01/07/22 at 11:00 PM by Administrative Nurse C -"CMA reported that ...has been physically aggressive and combative with staff this shift. He placed his hands around the staff members neck attempting to choke him and digging his nails into his neck ..." 01/08/22 at 11:30 AM- Late entry by Administrative Nurse C -"CMA reports that they found water coming out of the bathroom. The stopper was pushed down in the sink and the drain to the shower was covered. Water was running from the sink and the shower flooding his	S 190			

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S 190	Continued From page 3 apartment." 01/09/22 at 02:50 PM - Late entry by Administrative Nurse C - "CMA reports ...has been more lethargic today ...he has also been scratching his psoriasis to the point he has a skin tear on his elbow. Staff attempted to bandage the resident got violent ..." 01/18/22 at 16:01 PM by Administrative Nurse C - " ...was transported via ...to Saint Anthony's Behavioral Health Hospital for behaviors and medication management. His wife will meet him there". 02/14/22 at 03:41 PM by Administrative Nurse C - " ...returned from hospital today ...currently using a wheelchair for mobility ... he will need assistance with medications, bathing, activities of daily living (ADL's) toileting and cognition." 02/15/22 at 03:00 PM by Administrative Nurse C - " ...adjusting to his new environment without difficulty. He has not exhibited any behaviors ..." 2/16/22 at 08:16PM by Administrative Nurse C - " ...has not exhibited any behaviors ..." 3/30/22 at 06:25 PM by Administrative Nurse C - spoke with resident representative about R525 discharge from primary care physician services. Resident representative stated she would make a Zoom (online) appointment with a new physician as soon as possible. 04/18/22 at 04:00 AM by Administrative Nurse C - " ...observed sitting on the floor of his apartment ...noted to be agitated and combative ...staff assisted back to bed."	S 190		

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S 190	Continued From page 4 04/23/22 at 06:00 PM- Late entry by Administrative Nurse C - "staff reports that ...is agitated and aggressive this evening ...cannot be redirected ...sent via emergency medical services (EMS) to Advent Shawnee Mission for evaluation." 05/01/22 at 02:22 PM Late entry by Administrative Staff B - "from CMA wife has been very distraught all shift came in around 8 AM and has been here since. Husband has been sleeping all day ..." 05/01/22 at 05:00 PM Late entry by Administrative Nurse C - "received an email from ...wife, she was upset because ...had not been in his apartment since 8:00 PM. Spoke with staff on duty and was informed that ...was heard on the baby monitor in his apartment at approximately 8:00PM. Staff then brought ...to the commons living room for observation and safety." 05/01/22 at 5:00 PM by Administrative Nurse C - "received a message from resident representative this morning. She is concerned R525 has not been in his room and visible on the camera since approximately 8:00P. Staff informed me that R525 was restless in his apartment ...staff brought R525 to the living room for supervision ..." 05/02/22 at 03:52 PM by Administrative Nurse A - "resident representative R525 Durable Power of Attorney (DPOA), was given a 30 day notice of discharge. This notice was hand delivered ..." Record review of the facility provided "Notice of Discharge" stated the facility intended to discharge on 06/02/22, "as the facility cannot provide one on one care as requested by the DPOA ..."	S 190		

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S 190	Continued From page 5 The resident electronic progress notes lacked documentation of R525's representative requesting one-on-one care. Interview on 05/25/22 at 10:35 AM with Administrative Nurse A and Administrative Staff B, stated they hand delivered the letter, and explained to the resident representative that they were unable to meet the resident's needs based on the representative's request of one-on-one staff care at all times and supervision while the resident walked. Administrative Nurse A stated a second letter was provided on 5/3/2022, related to the ombudsman's statement the first letter provided to R525's representative did not specify the exact reason for the involuntary discharge. Administrative Nurse A and Administrative Staff B confirmed the resident record lacked the required documentation supporting the rationale for involuntary discharge and documentation in the clinical record from R525's physician supporting the rationale for the involuntary discharge. Interview on 05/25/22 at 01:30 PM with Advanced Practice Registered Nurse (APRN) D stated her last note on 03/30/22 documented R525 was discharged from TEAM Health Services. She did not provide a rationale to discharge him from the facility in May because he was not under her care at that time. The facility's undated "Discharge Criteria" policy documented "It is the policy to ensure that each resident is permitted to remain in the facility and not transferred or discharged without notification and process consistent with applicable state law/regulation."	S 190			