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 _____	C 08/03/2021

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 citations represent the findings of an abbreviated survey for complaints # 164213, 164426, 164434, 164470, 164169, 164079, 163807, and 163598 of the above named facility conducted on 7/26/2021, 7/27/2021, 7/28/2021, 7/29/2021, 8/2/2021 and 8/3/2021.	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 75 residents. The sample included 3 (#1, 2, 3) residents and 10 (#4, 5, 6, 7, 8, and 9, 10, 11, 12 and 13) focused reviews. Based on interview and record review the administrator failed to record the reason for the involuntary discharge in the resident record which included documentation from the resident's physician rational for the transfer/discharge being necessary for the resident's wellbeing and the facility not being able to meet the resident needs for resident #1, 4 and 5. Findings included: - Record review 7/26/2021 for resident #1 revealed an admission date of 7/23/2019, with diagnoses of chronic respiratory failure, bipolar disorder, fluid overload, personality disorder, and type 2 diabetes. Record review of the functional capacity screen dated 3/1/2021 revealed the resident required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. She had frequent incontinence and her cognition was intact. she required a walker or wheelchair for mobility, and she lacked the ability to manage her own medications. Record review of the negotiated service agreement dated 3/11/21 revealed the staff was to assist with bathing, dressing and undressing, and the resident was independent with mobility	S 190		

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using her cane or wheelchair for mobility.

Record review of the health service plan instructed staff to assist resident two times a week with showers, check and assist resident every 2 hours with toileting, and she was able to walk short distances with her cane or use her wheelchair for long distances.

Review of the electronic resident progress notes revealed the following entries:

6/22/2021 1:17 pm spoke with the social worker at the hospital, social worker stated that they were looking at discharging resident within 1 to 2 days and that she was looking to come back to the facility. Writer informed the social worker the resident had been a 2 person assist when she left the building and per facility regulations she needs a skilled stay prior to being reevaluated to come back to the facility.

6/23/2021 9:26 am review of the fax cover sheet from the hospital had the following hand-written note from the hospital social worker: therapy and nursing said she is just a 1 person assist and nursing even said she walked to the bathroom on her own. Doctor and therapy are just to ___ to return to assisted living with home health.

6/24/2021 1:24 pm report given writer from the hospital nurse, she reported ..... and she is a one person assist.....and she has been refusing assistance from hospital staff.

6/24/2021 at 5:01 pm Administration gave resident notice of discharge and order not to enter after 7/24/2021.

Record review of the electronic resident record on

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7/28/2021 revealed the electronic record lacked a copy of the involuntary 30 discharge notice provided to resident #1 on 6/24/2021, and the record lacked the physician documentation for rational for the discharge.

Interview on 7/27/2021 at 8:30 am with corporate director of operations A, revealed she was unable to find the involuntary 30 discharge notice provided to resident #1 on 6/24/2021.

- Record review on 7/26/2021 for resident #4 revealed an admission date of 9/30/2019, with diagnoses of heart failure, morbid obesity, diarrhea, overactive bladder, need for assistance with personal care.

Record review on 7/26/2021 of the functional capacity screen dated 2/8/2021 revealed the resident required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. She was incontinent of bladder and her cognition was intact, she was marked with inappropriate behavior and required supervision with her medications.

Record review on 7/26/2021 of the negotiated service agreement dated 2/8/2021 identified the staff to assist with toileting and incontinent issues, and resident was to be as independent as possible. Staff to help propel wheelchair when needed and resident had a walker for short distances.

Record review on 7/26/2021 of the health service agreement dated 2/8/2021 instructed staff to assist with showers 3 times a week and prn, the staff were to partially assist resident with

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dressing, and staff were to assist with toileting and incontinent issues as needed.

Record review of the electronic resident record on 7/27/2021 revealed the following entries:

3/15/2021 6:13 pm social services - late entry- resident received a 30 day notice due to the offensive smells coming from her room and noncompliance with incontinent care that is causing health issues with other residents. Resident was given a care plan meeting on 3/4/21 and told that she needed to comply with helping with her incontinent care, cleaning of her room, throwing briefs in the trash and not on the floor, or left in the bed. Resident was placed on a 2-hour toilet list and refuses to get up. the whole hallway smells of urine and we have had multiple complaints from residents and family members. Resident told administration that she was moving into an apartment when she got her stimulus check anyway so she didn't care about getting a 30-day notice.

Record review of the electronic resident record on 7/28/2021 revealed the electronic record lacked a copy of the involuntary 30 discharge notice provided to resident #4 and the record lacked the physician documentation for rational for the discharge.

Interview on 7/27/2021 at 8:30 am with corporate director of operations A, revealed she was unable to find the involuntary 30 discharge notice provided to resident #4.

- Record review on 7/27/2021 for resident #5 revealed an admission date of 7/6/2017 with diagnoses of heart failure, major depressive

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disorder, acute and chronic respiratory failure, and anxiety disorder.

Record review on 7/27/2021 of the functional capacity screen dated 2/20/2019 revealed the resident required physical assistance with bathing, dressing, and toileting, she was independent with walking/mobility, transferring and eating. She required physical assistance with medication management, was incontinent and used a walker or wheelchair for mobility.

Record review on 7/27/2021 of the negotiated service agreement reviewed and updated on 8/1/2019 identified staff to assist with showers and physical assistance with dressing. Staff to physical assist with toileting needs. Resident was independent with walker in her room and independent with her power chair for long distances.

Record review on 7/27/2021 of the health service plan updated on 8/1/2019 instructed staff to encourage resident to change in to clean clothes and assist with grooming and dressing daily and prn.

Record review on 7/27/2021 of Notice of Involuntary Transfer/Discharge record delivered to resident on 6/25/2019 revealed the resident was being involuntary discharged as of 7/26/2019 necessary for welfare and/or needs cannot be met: for continued refusal to assist with incontinence issues, or allow staff to assist with showers or peri care. Unable to meet hygiene needs, and Health of other is endangered in the adult care home; noncompliance to hygiene, causing strong odors through the community affecting other residents eating, activities and activities of daily living.

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S 190	Continued From page 6 Record review of the electronic record on 7/28/2019 revealed the record lacked the documentation from the physician providing rational for discharge/transfer was necessary for the resident's welfare and the resident needs not being met, and the physician documentation of rational for the transfer/discharge being necessary because of the health and safety of other individuals in the adult care home being endangered. The administrator failed to record the reason for the involuntary discharge in the resident record which included documentation from the resident's physician rational for the transfer/discharge being necessary for the resident's wellbeing and the facility not being able to meet the resident needs for resident #1, 4 and 5.	S 190		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105 (f) (11) The facility reported a census of 75 residents. The sample included 3 (#1, 2, and 3) residents and 10 (#4, 5, 6, 7, 8, 9, 10, 11, 12 and 13) focused reviews. Based on record review and	S3261		

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interview the administrator failed to ensure the resident record contained documentation of all incidents to include being discharged from the facility for resident's #'s 8, 9, 10, 11 and 13.

Findings included:

- Record reiew on 8/3/2021 for resident #8 revealed an admission date of 10/24/2018 with diagnoses of diverticulitis of the large intestine, hypertension, Alzheimer's disease, and bipolar disorder.

Record review on 8/3/2021 of the functional capacity screen dated 7/1/2020 revealed the resident required physical assistance with bathing, dressing and toileting, and her medications. She was frequently incontinent of bladder and had short term memory and memory recall impairment. She was marked with falls and used a walker for mobility.

Record review on 8/3/2021 of the negotiated service agreement dated 7/1/2020 identified staff would physical assist with showers, toileting, and ambulation as needed.

Record review on 8/3/2021 of the health service plan dated 7/1/2020 instructed staff to assist with showers 3 times a week and as needed, dressing, toileting every 2 hours, and stand by assist as needed with walker related to unsteadiness.

Record review of the electronic progress notes revealed the following entries:

2/23/2021 5:44 pm care plan meeting held today with resident #8 daughter, physician, licensed

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nurse, registered nurse, and resident #8 family member. Resident status discussed in regards to continued decline in mental health with her dementia, loss of appetite, need for more one on one care regarding confusion, forgetfulness, anxiety and fears associated with confusion / dementia....resident #8 daughter would like to find a memory care or a small home plus.....per family request and physician recommendations discharge planning is in effect at this time.....

3/2/2021 late entry and last note at 1:00 pm care plan meeting with durable power of attorney and case manager discussed needs and behaviors, family has decided to look at resident being taken to a home plus.

Record review on 7/27/2021 of the electronic clinical census under the billing tab of the electronic charting system revealed the following entry: 3/5/2021 stop billing.

Record review of the facility provided list of discharged residents revealed resident #8 discharged from the facility on 3/5/2021.

Interview on 7/29/2021 with corporate director of operations confirmed the resident record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action.

- Record review for resident #9 revealed an admission date of 9/20/2019 with diagnoses of type 1 diabetes, acute kidney failure, hydrocephalus, cystitis, hypertension, and pruritus.

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S3261	Continued From page 9 Record review on 8/3/2021 of the functional capacity screen dated 6/29/2020 revealed the she required physical assistance with bathing, dressing, toileting, and required supervision with transferring and walking. She required physical assistance with medication management, she was incontinent, and was marked with falls. She used a walker mobility device. Record review on 8/3/2021 of the negotiated service agreement dated 6/29/2020 identified the staff to assist with shower, and toileting. Resident was unsteady and had a history of falls. Record review on 8/3/2021 of the health service plan instructed staff to assist with showers 2 to 3 times a week, assist with dressing as needed, assist with compression hose, and to assist if resident is dizzy oar weak when ambulating. Record review of the electronic progress notes revealed the following entry as the last entry in the progress note section: 10/9/2020 resident was seen 10/8/2020 by advanced practice registered nurse for resident physician. a pharmacy not to physician that was obtained after request for medication review was given for frequent falls. Order to start antibiotic faxed to pharmacy and processed. Record review of the electronic clinical census under the billing tab of the electronic charting system revealed the following entry: 11/3/2020 status hospital leave. Record review on 7/27/2021 of the facility provided list of discharged residents revealed resident #9 discharged from the facility on 12/6/2020.	S3261		

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S3261	Continued From page 10 The electronic record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action. Interview on 7/29/2021 with corporate director of operations confirmed the resident record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action. - Record review for resident #10 revealed and admission date of 3/1/2021 with diagnoses of type 1 diabetes, chronic obstructive pulmonary disease and hypertension. The electronic record lacked the functional capacity screen, negotiated service agreement and health service plan. Record review of the electronic progress notes revealed the following entry; 5/7/2021 11:06 am resident arrived to facility from skilled nursing facility via wheelchair by staff and his medications were delivered. He denies pain at this time and he was wheeled to his room in stable condition. Medications added, sent to pharmacy and ____ for durable power of attorney. Record review of the electronic clinical census under the billing tab of the electronic charting system revealed the following entry: 3/2/2021 status hospital leave. Record review on 7/27/2021 of the facility provided list of discharged residents revealed resident #10 discharged from the facility on 5/17/2021.	S3261		

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S3261	Continued From page 11 The electronic record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action. Interview on 7/29/2021 with corporate director of operations A revealed the resident went to skilled care on 3/5/2021. She confirmed the resident record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action. - Record review for resident #11 revealed an admission date of 12/3/2017 with diagnoses of paranoid schizophrenia, cerebral infarction, type 2 diabetes, and major depressive disorder. Record review on 8/3/2021 of the functional capacity screen dated 2/21/20220 revealed the resident required physical assistance with bathing, dressing, toileting, and transferring. He was independent with walking and eating, he required physical assistance with his medications, marked with falls and unsteadiness, and he used a walker for mobility. Record review on 8/3/2021 of the negotiated service agreement dated 2/21/2020 identified the staff would assist with bathing, dressing and toileting, and the resident had a walker and wheelchair and staff to assist with propelling wheelchair as needed. Record review on 8/3/2021 of the health service plan instructed staff to assist with dressing as needed per resident request, assist with bathing several times a week. Resident was independent	S3261		

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with wheelchair and staff to assist as needed when resident using his walker.

Record review on 8/3/2021 of the electronic progress notes revealed the following entry as the last entry in the electronic progress notes; 5/13/2020 3:06 pm seen by advanced practice registered nurse via tele medicine today. No new orders received. Resident is stable at this time.

Record review on 7/272021 of the electronic clinical census under the billing tab of the electronic charting system revealed the following entry; 6/19/2021 status of hospital leave.

Record review on 7/27/2021 of the facility provided list of discharged residents revealed resident #11 discharged from the facility on 6/19/2020.

The electronic record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action.

Interview on 7/29/2021 with corporate director of operations confirmed the resident record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action.

- Record review on 7/27/2021 for resident #13 revealed and admission dated of 8/3/2021 with admitting diagnoses of idiopathic chronic gout, manic episode, angina, and type 2 diabetes.

Record review on 8/3/2021 of the functional capacity screen dated 2/21/2021 revealed the

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resident wans independent with all activities of daily living, he required physical assistance with his medications, and his cognition was intact.

Record review on 8/3/2021 of the negotiated service agreement dated 2/21/2021 identified the resident was independent with all self-cares and the facility would manage his medications.

Record review on 8/3/2021 of the health service plan dated 2/21/2021 instructed staff to assist as needed with personal hygiene, dressing and facility to administer his medications.

Record review on 7/29/2021 of the electronic progress notes revealed the following entries:

4/16/2021 12:37 pm current care plan, encourage exercise daily at least 30 minutes and reduce red meat intake and fats. Patient states that he eats sausage, egg and bacon every morning and may even get an early breakfast and fast food restaurant.....

5/9/2021 5:37 pm with dad

Record review on 7/29/2021 of the electronic clinical census under the billing tab of the electronic charting system revealed the following entry; 5/31/2021 status stop billing.

Record review on 7/27/2021 of the facility provided list of discharged residents revealed resident #11 discharged from the facility on 5/31/2021.

The electronic record lacked the documentation of the indications of illness or injury, including the date and time of the occurrence, action taken and the results of the action.

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 _____	C 08/03/2021

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
S3261	Continued From page 14 Interview on 7/29/2021 with corporate director of operations revealed the resident had received a 30 day notice of rate increase and the resident's father gave the facility a 30 day notice at that time. She confirmed the resident record lacked the documentation of the indications including the date and time of the occurrence, action taken and the results of the action. The administrator failed to ensure the resident record contained documentation of all incidents to include being discharged from the facility for resident's #'s 8, 9, 10 11 and 13.	S3261		