Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063011	A. BUILDING: _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE ESTATES, INC	1354 TAYLOR ROAD INDEPENDENCE, KS 67301

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with complaint #'s 147249 and 1478791 for the above named facility conducted on 3/30/2021, 3/31/2021 and 4/1/2021.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103 (h) (1) (A) The facility census equaled 25 with 3 sampled	S 135		

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

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S 135	Continued From page 1	S 135		

and 1 (#112) focused review. Based on record review and interview for 1 of 4 sampled residents the facility failed to consult with the resident physician and notify the resident's legal representative upon occurrence of an accident and had the potential for requiring a physician's intervention.

Findings included:

- Review of resident #112 records on 3/30/3021 at 1:00 pm revealed an admission date of 1/1/2019 with diagnoses of atrial fibrillation, diabetes, congestive heart failure, low iron, and chronic kidney disease.

Review of the admission functional capacity screen dated 1/1/2019 on revealed resident #112 had no cognitive deficits and required physical assistance with bathing and dressing. She required physical assistance to manage her medications and treatments and used a walker mobility device.

Review of the admission negotiated service agreement on dated 1/1/2019 instructed staff to physical assist with bathing, required supervision when using walker, and was independent with transfers.

Review of the paper nursing notes revealed the following:

untimed entry on 10/30/2019; resident ambulating to supper with walker. Tripped on tip of shoe and floor fell face first. "Ref" to go to emergency room and requested to be assisted up. Able to move all extremities per usual. Staff assist x4 up to dining room.

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S 135	Continued From page 2 untimed entry on 10/31/2019; resident out for breakfast but not wanting to come to lunch or to eat. untimed entry on 11/1/2019; resident out to breakfast and lunch. not wanting to come out for supper, requesting an ice pack for the left leg. untimed entry on 11/2/2019; resident out to breakfast without difficulty. Not wanting to come to table rest of weekend and requested Monday to be seen by doctor. untimed entry on 11/4/2019; resident complaining being short of breath at 4:00 AM, ambulance called, oxygen saturation level 80 to 84 % and resident transferred to hospital. Interview with operator A on 3/30/2021 at 2:30 PM confirmed that "Ref" meant resident refused. Operator A confirmed the nursing notes lacked any documentation of resident physician and legal representative being notified of fall on 10/30/2019. The facility failed to consult with the resident physician and notify the resident's legal representative upon occurrence of an accident and had the potential for requiring a physician's intervention.	S 135		
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	S3261		

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S3261	Continued From page 3	S3261		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-105 (f) (11)

The facility census equaled 25 with 3 sampled and 1 (#112) focused review. Based on record review and interview for 1 of 4 sampled residents the facility failed to document the incident, symptoms, or indications of illness or injury to include the date and time of the incident, actions taken, and results of the actions taken.

Findings included:

- Review of resident #112 records on 3/30/3021 at 1:00 pm revealed an admission date of 1/1/2019 with diagnoses of atrial fibrillation, diabetes, congestive heart failure, low iron, and chronic kidney disease.

Review of the admission functional capacity screen dated 1/1/2019 on revealed resident #112 had no cognitive deficits and required physical assistance with bathing and dressing. She required physical assistance to manage her medications and treatments and used a walker mobility device.

Review of the admission negotiated service agreement on dated 1/1/2019 instructed staff to physical assist with bathing, required supervision when using walker, and was independent with transfers.

Review of the paper nursing notes revealed the following:

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S3261	Continued From page 4	S3261		

untimed entry on 10/30/2019; resident ambulating to supper with walker. Tripped on tip of shoe and floor fell face first. "Ref" to go to emergency room and requested to be assisted up. Able to move all extremities per usual. Staff assist x4 up to dining room.

untimed entry on 10/31/2019; resident out for breakfast but not wanting to come to lunch or to eat.

untimed entry on 11/1/2019; resident out to breakfast and lunch. not wanting to come out for supper, requesting an ice pack for the left leg.

untimed entry on 11/2/2019; resident out to breakfast without difficulty. Not wanting to come to table rest of weekend and requested Monday to be seen by doctor.

untimed entry on 11/4/2019; resident complaining being short of breath at 4:00 AM, ambulance called, oxygen saturation level 80 to 84 % and resident transferred to hospital.

Review of the history and physical from provider D performed on 11/4/2019 revealed the following: bruise noted to the left forehead, and left leg swollen with erythematous discoloration.

Review of orthopedic consultation from provider E performed on 11/4/2019 revealed the following: tender to palpation over hematoma proximally on anterolateral leg.

Interview with operator A on 3/30/2021 at 2:30 PM confirmed that "Ref" meant resident refused. Operator A confirmed the nursing notes lacked documentation of the time of the incident, and any fall follow up for the fall on 10/30/2019.

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S3261	Continued From page 5 The facility failed to document the incident, symptoms, or indications of illness or injury to include the date and time of the incident, actions taken, and results of the actions taken.	S3261		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3) The facility census equaled 25 with 3 sampled and 1 focused review. Based on interview and record review the facility failed to perform quarterly reviews of the facility's emergency management plan with employees and residents.	S3280		

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S3280	Continued From page 6 Findings included: - Record review on 3/30/2021 at 1:00 PM of the facility emergency preparedness training revealed the only documentation provided was for training provided on 1/21/2021. Interview on 3/30/2021 with operator A confirmed the lack of documentation of emergency preparedness training for the prior 3 quarters. The facility failed to perform quarterly reviews of the facility's emergency management plan with employees and residents.	S3280		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced	S3298		

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S3298	Continued From page 7 by: KAR 26-41-206 (d) The facility census equaled 25 with 3 sampled and 1 focused review. Based on observation, record review and interview the facility failed to ensure the food was being served at the proper temperature. Findings included: - Record review on 3/30/2021 at 10:35 AM of the food temperature log revealed the most recent date recorded for food temperatures was on 7/2020. Interview on 3/30/2021 at 10:35 AM with kitchen staff C confirmed she did not write down food temps. Interview on 3/30/2021 at 10:45 AM with operator A confirmed the food temperature log lacked current documentation of food temperatures being obtained. The facility failed to ensure the food was being served at the proper temperature.	S3298		