STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B049001	A. BUILDING: _____ B. WING _____	R 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN SENIOR LIVING LLC	321 N MAIN STREET HAVILAND, KS 67059

(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 citation represents the findings of a revisit survey at the above named Home Plus facility conducted on 3/15,16/2021.	{S 000}		
{S5155} SS=G	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of 9 residents. The sample included 3 residents. Based on interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 1(#1316) of 3 sampled residents by ensuring the bed alarm and motion sensor were in proper functioning order prior to the resident having a fall which resulted in a fractured hip. Findings included: Review of resident #1316's medical record revealed the resident moved into the facility on 12-18-20 with a diagnosis of Dementia.	{S5155}		

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

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{S5155}	Continued From page 1	{S5155}		

Review of resident's admission functional capacity screen dated 12-9-20 revealed the resident needed physical assistance with bathing, dressing, transfers, and walking/mobility. It also identified a score of 4 related to cognition, memory, and recall indicating the resident had cognitive impairment. The resident also had current or recent problems with falls/unsteadiness and impaired decision-making. The resident used a walker for mobility assistance.

The negotiated service agreement (NSA) dated 12-9-20 stated staff to provide assistance with ambulation/transfers at all times and fall prevention measures to be in place at all times.

The NSA failed to identify what the fall prevention measures were.

Review of the health care service plan dated 12-9-20 identified staff would assist the resident with mobility using her walker and stand by assist during ambulation at all times. It also identified the facility managed risk factors for falls but failed to identify how those risk factors were managed.

The care plan in the electronic medical record provided by operator A updated on 2-19-21 lacked information that the resident used a walker. It identified staff to assist the resident with transfers and ambulation to meals and toileting but failed to identify how staff were to assist the resident.

Both the health care service plan and the electronic care plan failed to identify use of a gait belt with ambulation; and use of a pressure pad alarm and a motion detector when in bed.

Review of the daily information sheet provided by

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{S5155}	Continued From page 2	{S5155}		

licensed nurse B revealed the resident required 1 person assist, had a bed alarm and motion sensor, she did not use the call light and when staff heard the alarm beep they needed to offer to take the resident to the bathroom.

Review of the nurses notes revealed the following:
3-8-21 at 2:37 PM certified staff D noted she observed the resident lying on her left side on the bathroom floor and went and got licensed nurse B.
3-8-21 at 2:40 PM licensed nurse B documented upon entering the resident's room the resident laid on the bathroom floor and when she and operator A assisted the resident to a sitting position the resident complained of pain while grabbing at her left hip. The resident's left hip appeared noticeably shorter and had external rotation. The resident's husband was notified of fall and local emergency management services (EMS) was notified a 1:57 PM. Resident was then transferred to local hospital via EMS. Nurse B also documented staff will enforce use of call light and motion alarm upon resident's return.

On 3-16-21 at 10:43 AM licensed nurse B reported the resident is supposed to have a motion detector in her room and she had one in her room but was covered up by blankets and it did not alarm when the resident got out of bed. Nurse B stated that there are daily sheets that include all the specific things each resident needed to have outside of basic cares. Nurse B stated the resident had fallen at home prior to admission so staff put a gait belt on the resident and used a walker just to make sure she is safe.

On 3-16-21 at 11:25 AM certified staff C reported

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{S5155}	Continued From page 3	{S5155}		

staff assisted the resident with daily cares including bathing and dressing. The resident can get confused when she uses the walker so sometimes we just walk with her. Staff C also reported the resident had a bed alarm for when she sits on it or lays on it in the bed that goes off when she starts to move. She also has a motion alarm that is kept under the bed so that it will go off if she gets out of bed. Staff C stated the information on how to care for the resident is in the care plan and we are also told in report to make sure alarms are on and working.

On 3-16-21 at 12:32 licensed nurse B reported when the resident fell the staff did have the alarm on the bed as well as the motion sensor but neither one of them alarmed. Nurse B stated the bed alarm is a battery operated one and it needed a new battery and the motion alarm did not sound because it was covered up with bed covers. Nurse B stated as far as she knows the facility did not a system to check the batteries on a routine basis.

Review of the undated fall policy revealed any ordered/recommended interventions will be added to the Health Service Plan as appropriate. The administrative staff may complete an addendum to the Negotiated Service Agreement as needed to incorporate the plan.

The operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of resident #1316 by ensuring the bed alarm and motion sensor were in proper functioning order prior to the resident having a fall which resulted in a fractured hip.