Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N097003	A. BUILDING: _____ B. WING _____	C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW ESTATES RETIREMENT COMMUNITY, INC	1630 SEWELL AVENUE COLBY, KS 67701

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #156978, #156882, #156744, #156743, #156771, #156785, #156578 at the above named assisted living facility conducted on 11/2/2020, 11/03/2020, 11/04/2020, 11/05/2020, 11/09/2020, 11/10/2020, 11/12/2020, 11/16/2020 and 11/17/2020.	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 25 residents. The sample included 6 focused review residents and 1 closed record review. Based on record review and interview for 1(#11) of 6 focused review resident, the operator failed to ensure no resident was subjected to neglect when the licensed nurse failed to assess and provide or coordinate services reasonably necessary to ensure the resident's safety and well-being and to avoid harm when the resident was not assessed at the time of admission to the facility. This failure placed the resident in immediate jeopardy for harm, injury or death.	S3026		

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

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S3026	Continued From page 1 Findings included: - Review of resident #11's medical record revealed he admitted to the facility on 10/08/2020 with diagnosis of Type II Diabetes Mellitus, obstructive sleep apnea, and obesity. The admission functional capacity screen (FCS) dated 10/12/2020 recorded resident required physical assist with bathing, toileting, bladder incontinence and management of medications and treatments. The FCS further recorded "PT (physical therapy) and wound management" under ordered therapies and treatments and "will need assist with lower leg management and care." The FCS was signed by licensed nurse #B and dated 10/12/2020. Record lacked admission negotiated service agreement (NSA). The admission Resident Plan of Care dated 10/12/2020 recorded staff to assist resident with bathing two times per week and staff to assist with toileting. The Resident Plan of Care failed to address management of medication, treatments and bladder incontinence. Resident in hospital during on site revisit and abbreviated survey. Resident returned to facility on 11/06/2020. Witness statement from certified staff #C provided on 11/03/2020 at 12:57 PM recorded. "I was working when (resident #11) was brought to our facility ...He said his legs were wrapped and had been infected previously, and he had dressing changes usually after he showered. We	S3026		

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discussed cares and he said he was very independent and did not need much help. He walked with a cane. He is a very large man and looked puffy all over. His legs were wrapped, and I did not remove the wraps as I was advised not to by our RN and administrator. Neither were in the building when he arrived, but I communicated via phone with them." He told me he needed oxygen, but I did not see the order for any in the paperwork that was given to me, so I notified administrator of his statement."

The facility failed to provide admission orders for oxygen therapy or bilateral leg treatment.

On 11/12/2020 at 2:20 PM, operator confirmed she cannot find admission orders for oxygen or bilateral leg treatments.

Signed physician's orders dated 10/07/2020 recorded DuoNeb Solution 0.5-2.5 (3) milligrams (mg)/3 milliliters (mL) 1 inhalation inhale orally via nebulizer three times a day for shortness of air (SOA) related to shortness of breath.

October 2020 Medication Explanation Log recorded "Duoneb Solution Nebulizer unavailable" eleven times from 10/09/2020 to 10/12/2020, signed by certified staff #E and #K.

Record lacked documentation of an assessment or nurse's notes from licensed nurse #B upon assessment of resident on 10/12/2020.

Nurse's note dated 10/13/2020 at 10:00 AM by Certified staff #D recorded, "(Resident #11) was admitted with CHF (congestive heart failure), cellulitis of lower legs, and hypoxia."

Witness statement from operator provided on

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S3026	Continued From page 3 11/02/2020 at 7:00 PM recorded, "On October 1st at 8:45 PM I notified licensed nurse #B that we would be getting a new resident on October 8, 2020 from (another health care facility). She acknowledged me on October 2nd, 2020 at 7:45 PM. On October 8th, 2020 resident arrived in the facility at 1310 (1:10 PM) per CMA on duty. (Previous health care facility) did not leave concentrator as resident is on oxygen 1-4 liters will need more care! Again, she never said anything of what he had done in the past and so forth. On October 12th, received text from licensed nurse #B stating that she had sent me a private text regarding the new resident. She basically said he was a mess and that we needed to watch him, on October 12th, CMA went into his apartment and noted that his bathroom had bowel movement all over the floor and he had stated that staff would come back in and never did over the weekend. CMA sent over a picture regarding his bathroom and it was a mess. He was sent to the hospital after supper is what I understand, to which licensed nurse #B sent me a text at 1614 (4:14 PM) on October 12th stating that was going to happen. I am not sure why they waited so long to call for an ambulance." Witness statement from licensed nurse #B provided on 11/03/2020 at 8:08 AM, which dated the incident happened on 10/12/2020, and recorded, "Early in the week before resident #11 was admitted, (the operator) told me we were getting a new admit. Nothing about his status. On Thursday (certified staff #C) called wanting to know if I would come do an evaluation on him. I told her I was exposed to Covid once again and was in quarantine until Monday and she stated agency nurse would be in the weekend. I did come in that Monday to find (resident #11) sitting in recliner with no TV or radio, bed or anything.	S3026		

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Resident had leg wraps on that were weeping. His scrotum was hanging to his knees. He told me he had parasites in his stomach. He was wearing O2 at 4 Liters. He stated he was bleeding from his rectum. I went to see what orders were in place. No orders for leg dressings, O2, and an order for nebulizer treatments. Box of solution that had not been opened. I asked why- the response I got was they didn't have a machine. I was floored we didn't get one. I visited with resident and left facility. I notified operator about the substandard care. She stated she had pulled strings to get an O2 concentrator. No orders found. She then said we had orders but must of been misplaced. I then had the 2-10 shift send him to ER to get proper treatment on legs, possible parasites with bleeding and nebulizer treatments. He was admitted to the hospital with cellulitis, hypoxia, CHF. I then notified the State of Kansas of the substandard care."

Nurse's note dated 10/12/2020 at 3:00 PM by certified staff #D recorded, "CMA to (resident #11's) room to introduce myself to resident #11 and let him know I was on duty till 2200 (10:00 PM), if he needed anything. He began telling me there was a mess in the bathroom on the floor. He said it was blood in his stool. I went to go look and this black-reddish BM (bowel movement) was on the floor. Resident #11 said it had been there for at least 2 days. Said he had told the lady before me and all she said was I will be back but never came back. I called the RN (registered nurse) (licensed nurse #B) to report my findings. Resident #11 continued to tell me he has not had his breathing treatment, I looked at the MAR (medication administration report) and notified they are ordered TID (three times a day) on the explanation log the shifts prior to mine was writing Nebulizer unavailable. Resident #11 was on 4 L

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(liters) of O2 (oxygen) with no Dr. (doctor) order. His legs (both) were swollen and weeping that his bandages were wet and had wet spots on his jeans. RN spoke to Doug so she could hear the complaints, after speaking with him and my report on him, RN advised to call 911 to send to hospital. EMTs (Emergency Medical Technician) came and left at 1845 (6:45 PM). (Resident #11) was admitted."

Witness statement from certified staff #D provided on 11/03/2020 at 10:11 AM recorded, " ...then later I went into (resident #11's room) to go introduce myself ...right after I walked in I asked him how he was doing. Resident started saying he hadn't had a shower since he arrived and he was having blood from rectum and seeping from his legs, resident also said he had no breathing treatments. I called licensed nurse #B from his room to let (resident #11) tell her what all was going on ...Licensed nurse #B told me to call 911 and have him go the ER. (Resident #11) was supposed to have his legs changed 2 or 3 days but hadn't had them changed since he arrived. The legs were seeping through his pant leg ...EMT's came and loaded him up ... They admitted him for hypoxia, CHF, cellulitis."

Witness statement from emergency staff member #L provided on 11/03/2020 at 11:59 AM recorded, "EMS (Emergency Medical Services) responds to a 911 call ...for a male needing transported to the hospital and possible lift assist ... There were 3-4 piles of stool dried up on the floor of the patient's restroom that had not been cleaned up ...The patient did state he had a bowel movement today (10-12-2020) that was pale yellow color. I asked the CMA what we were transferring the patient to the ER (emergency room) for and she said to get him the help he needs, as in bandages on legs

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changed and a shower. The only patient info (information) given to us by the CMA was a medication list which was given to the ER staff, patient did have a blood glucose level of 434 taken before turnover to the ER ...The only question the patient had asked was why was nobody changing his bandages?...EMS was called at 1844 (6:44 PM) and arrived at the facility at 1851 (6:51 PM)."

Telephone interview on 11/05/2020 at 12:09 PM with licensed nurse #B stated she did not take dressings off resident's legs because, "I didn't know what I was going to find" and did not have orders to redress them. Licensed nurse #B confirms she did not assess resident's legs and confirms legs were weeping at the time of her assessment.

Telephone interview on 11/05/2020 at 11:53 AM with certified staff #C stated licensed nurse #B came in on 10/12/2020 to assess resident and left the facility at approximately 11:42 AM, based off of a text message she sent operator to let operator know licensed nurse #B left the facility.

Resident was assessed by licensed nurse #B on 10/12/2020. Certified staff #D was on duty on 10/12/2020 from 2:00 PM to 10:00, went to resident's room at 3:00 PM, called licensed nurse #B regarding resident's condition, and resident was not transported to the ER until 6:51 PM that evening.

The jeopardy was removed on 10/12/2020 at 6:51 PM when EMS arrived to the facility and the resident was transported to the hospital.

The operator failed to ensure no resident was subjected to neglect when the licensed nurse

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S3026	Continued From page 7 failed to assess and provide or coordinate services reasonably necessary to ensure the resident's safety and well-being and to avoid harm when the resident was not assessed at the time of admission to the facility. This failure placed the resident in immediate jeopardy for harm, injury or death.	S3026		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-201(a) The facility reported a census of 25 residents. The sample included 6 focused record review residents and 1 closed record review resident. Based on record review and interview, the operator failed to ensure 1 (#11) of 6 focused review residents were screened on or before admission to determine the individual's functional	S3080		

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S3080	Continued From page 8 capacity. Findings included: - Review of resident #11's medical record revealed he admitted to the facility on 10/08/2020 with diagnoses of Type II Diabetes Mellitus, obstructive sleep apnea, and obesity. Review of the admission functional capacity screen (FCS) dated 10/12/2020, four days after admission to the facility. Witness statement obtained on 11/02/2020 from operator, which stated the resident arrived at the facility on 10/08/2020 at 1:10 PM. Witness statement obtained on 11/03/2020 from licensed nurse #B, which stated she was in the facility on 10/12/2020 to assess the resident. The operator failed to ensure appropriate staff completed the functional capacity screen on or before admission to the facility.	S3080		
S3091 SS=D	26-41-202 (e) NSA Nurse Participation (e) A licensed nurse shall participate in the development, review, and revision of the negotiated service agreement if the resident's functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by:	S3091		

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S3091	Continued From page 9 KAR 26-41-202 (e) The facility reported a census of 25 residents. The sample included 6 focused record review residents and 1 closed record review resident. Based on record review and interviews, for 1 (#11) of 6 focused record review residents, the operator failed to ensure a licensed nurse participated in the development of the negotiated service agreement (NSA) when the Resident's functional capacity screen (FCS) indicated the need for health care services. Findings included: - Review of resident #11's medical record revealed he admitted to the facility on 10/08/2020 with diagnoses of Type II Diabetes Mellitus, obstructive sleep apnea, and obesity. The admission FCS dated 10/12/2020 recorded resident required physical assist with bathing, toileting, bladder incontinence and management of medications and treatments. The admission Resident Plan of Care dated 10/12/2020 recorded staff to assist resident with bathing two times per week and staff to assist with toileting. The Resident Plan of Care failed to address management of medication and treatments and bladder incontinence. On 11/05/2020, requested admission NSA for resident #11. Record lacked admission NSA for resident. On 11/05/2020 at 2:58 PM, operator confirmed resident was not assessed upon admission to the facility on 10/08/2020 and no NSA had been	S3091		

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S3091	Continued From page 10 developed. Witness statement obtained on 11/03/2020 from licensed nurse #B, which confirmed she was in the facility on 10/12/2020 and saw resident #11. The operator failed to ensure a licensed nurse participated in the development of the NSA when the Resident's FCS indicated the need for health care services.	S3091		
S3167 SS=D	26-41-204 (f) Health Care Services (f) Each administrator or operator shall ensure that a licensed nurse is available to provide immediate direction to medication aides and nurse aides for residents who have unscheduled needs. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (f) The facility reported a census of 25 residents. The sample included 6 focused record review residents and 1 closed record review residents. Based on record review and interview for 1 (#11) of 6 focused record review residents, the operator failed to ensure a licensed nurse was available to provide immediate direction to medication aides and nurse aides for the resident who had unscheduled needs. Findings included:	S3167		

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- Review of resident #11's medical record revealed he admitted to the facility on 10/08/2020 with diagnoses of Type II Diabetes Mellitus, obstructive sleep apnea, and obesity.

The admission functional capacity screen (FCS) dated 10/12/2020 recorded resident required physical assist with bathing, toileting, bladder incontinence and management of medications and treatments. FCS completed 4 days after resident's admission to facility.

Record lacked admission negotiated service agreement (NSA).

The admission Resident Plan of Care dated 10/12/2020 recorded staff to assist resident with bathing two times per week and staff to assist with toileting. The Resident Plan of Care failed to address management of medication and treatments and bladder incontinence. Resident Plan of Care completed 4 days after admission.

Record lacked documentation of an admission assessment or nurse's notes from licensed nurse #B upon resident's arrival to the facility.

Witness statement from operator provided on 11/02/2020 at 7:00 PM recorded, "On October 1st at 8:45 PM I notified licensed nurse #B that we would be getting a new resident on October 8, 2020 from another health care facility. On October 10, 2020 is when I was notified that licensed nurse #B had been on quarantine for the 2nd time and that she would be in on Monday October 12th to see the new resident."

Witness statement from licensed nurse #B

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S3167	Continued From page 12 provided on 11/03/2020 at 8:08 AM, which dated the incident happened on 10/12/2020, and recorded, "Early in the week before resident #11 was admitted, (the operator) told me we were getting a new admit. Nothing about his status. On Thursday (10/08/2020) (certified staff #C) called wanting to know if I would come do an evaluation on him. I told her I was exposed to Covid-19 once again and was in quarantine until Monday." Resident #11 sent to the ER (emergency room) on 10/12/2020 at 6:51 PM by EMS (Emergency Medical Services) with diagnoses of CHF (congestive heart failure), cellulitis, and hypoxia. Telephone interview on 11/05/2020 at 12:09 PM with licensed nurse #B stated she had COVID-19 previously but was exposed to COVID-19 again and was advised to quarantine from the facility for 7 days. Licensed nurse #B stated she was quarantined until 10/11/2020. Licensed nurse #B was quarantined from 10/05/2020 to 10/11/2020. Facility without a licensed nurse on call for 7 days. Operator not aware of licensed nurse #B quarantined from the facility until 10/10/2020. The operator failed to ensure a licensed nurse was available to provide immediate direction to medication aides and nurse aides for the resident who had unscheduled needs.	S3167		