STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087067	A. BUILDING: _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVITA SENIOR LIVING AT ROLLING HILLS	629 S MAIZE COURT WICHITA, KS 67209

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S 000	INITIAL COMMENTS The following citations represent the findings of resurvey with complaints #141243 and #133072 at the above named facility on 6/19/19, 6/20/19, 6/24/19, 6/25/19, 6/26/19, 7/1/19, and 7/2/19.	S 000		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(C)(2) The facility identified a census of 72 residents. The sample included 6 residents and 1 closed record review. Based on 2 (#211 and #677) of 6 sampled residents, designated facility staff failed to conduct a Functional Capacity Screening (FCS) following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #211 on 6/20/19 at 2:35 p.m. revealed an admit date of 7/24/18 with diagnoses Dementia without Behaviors, Alzheimer's, and Gout.	S3081		

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

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The FCS dated 7/24/18 recorded resident required supervision for bathing, dressing, toileting, transfer, walking/mobility, experienced short-term memory loss and poor memory recall. The FCS indicated resident independent with decision making and had not experienced wandering or socially disruptive inappropriate behaviors.

The progress notes (nurses notes) recorded the following:

11/22/18 at 6:19 p.m. staff called this nurse and stated resident was out in the court yard trying to climb over the fence and as nurse walked over she found resident up just about on top of the fence. Resident had one foot on the brick wall and the other one on fence just about able to get over. This nurse talked resident into coming down and got him/her back inside. Family called to come and sit with resident. Signed Licensed nurse H.

12/7/18 at 11:10 a.m. Family member came to talk to this nurse and stated while visiting resident he/she got upset with him/her and wanted him/her to leave. Family member started walking out door and resident slammed the door closed so he/she could not get out. He/she dropped to the floor and was dragged across the room by legs. This nurse asked why he/she did not say anything and he/she stated, "I don't know." Informed to tell staff when something like that happens. Staff have heard resident curse at him/her. Signed Licensed Nurse H.

12/11/18 at 3:47 p.m. Resident is agitated and wanting to go home and stated he/she was only supposed to be here two to three days. Activity Aide stated resident tried going out of the door

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behind him/her and told resident he/she could not leave. When door closed the resident hits the door. Signed Licensed Nurse H.

1/9/19 at 1:56 p.m. Resident has had increase in exit seeking behavior. Increase in aggressive behavior with staff. Resident is at times redirected to "his/her work room" other times has gone to nursing office to speak about discharge. Resident is content for a couple of hours but again will start exit seeking. Today, after physical aggression with staff, doctor was consulted and gave orders to send to behavior unit hospital. Signed Licensed Nurse A.

1/9/19 at 6:00 p.m. Resident very upset and asking staff to open the door and just let him/her out. When staff replies that they could not open the doors he/she became more upset. Resident grabbed staff member by the right arm hard causing redness. Staff got away from resident and he/she followed him/her to solarium grabbing uniform. This nurse tried to redirect resident by telling him/her that there was no discharge until paper work was received. During this time staff was able to give medication for anxiety. Notified director of nurses and family. Signed Licensed Nurse I.

No documentation to indicate resident left the facility. No documentation in nurses notes until 1/21/19.

1/21/19 3:59 p.m. Resident returned to facility at 12:00 noon alert to person and denied discomfort. Resident has been looking for the door to leave the facility. Resident went out to courtyard and walked around. Signed Licensed Nurse H.

6/14/19 at 6:30 p.m., this nurse was getting report

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in assisted living when memory care unit staff called to report that his resident had jumped over the fence using a chair on the 100-side patio. This nurse and other staff members immediately started searching for resident. This nurse notified director of nursing of incident and directed me to call 911 and notify family. As this nurse was on phone with 911, I walked over to 100-unit side of memory care unit and seen resident had been found and safely returned to unit. Staff member who found resident report that he/she found resident outside by the garages by assisted living and was able to direct resident back to memory care unit without incident. Resident was alert but confused to time which is normal for him/her. Resident started playing pool. Vital signs blood pressure 122/77, pulse 89, respiration 20, temp 98.2 degrees. Range of motion normal, no complaints of discomfort. At 7:00 p.m. resident asleep. Signed Licensed Nurse J.

6/14/19 at 3:06 p.m. Physician notified regarding leaving the building. No new orders except to monitor. Signed Licensed Nurse A.

No further incidents noted.

Interview on 6/20/19 at 10:40 a.m. with Licensed Nurse A stated and confirmed a significant change FCS should have been conducted.

The record lacked a significant change FCS to identify resident experienced decision making, impaired decision making, wandering, and socially disruptive inappropriate behaviors.

- Record review for resident #677 on 6/24/19 revealed admit date of 2/8/19 with diagnoses of Cognitive Impairment and Epilepsy.

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S3081	Continued From page 4 The FCS dated 2/18/19 recorded resident required supervision with bathing, dressing, toileting, transfer, walking/mobility, experienced falls/unsteadiness, long-term memory loss, memory recall, and decision making. The FCS recorded resident independent with decision making and failed to identify resident exhibited socially disruptive inappropriate behaviors. The progress notes (nurses notes) recorded the following: 4/2/19 at 4:30 p.m. this nurse was informed that resident came out of room, walked over to another resident sitting on the couch, "balled fist up and stated are you going to sing that shit all day", the other resident jumped up off couch and got into resident #677's face and pushed other resident back down on couch. Staff broke the two up. Family, physician, and director of nurses notified. Signed Licensed Nurse H. 5/12/19 at (unknown time) Resident was verbally abusive to staff this evening. An incident involving another resident was transpiring. Resident became upset and felt that not enough was being done to care for another resident. Resident stated was going to call the police. "This nurse informed him/her that he/she was a Licensed Nurse and the situation will be handled appropriately. Resident stated, 'you guys' are a bunch of dumb bitches and don't know shit. Resident was not easily redirected." Signed Licensed Nurse K. No further documentation of inappropriate behaviors.	S3081		

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S3081	Continued From page 5 Interview on 6/24/19 at 10:45 a.m. with Licensed Nurse A stated and confirmed the FCS lacked documentation to indicate resident experienced impaired decision making, and socially disruptive behaviors. A significant change FCS was not conducted. For resident #677 an FCS was not conducted when resident had significant change with cognition and behaviors. For residents #211 and 677, designated facility staff failed to conduct an FCS following any significant change in condition as defined in K.A.R. 26-39-100.	S3081		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility 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 26-41-204(a) The facility identified a census of 74 residents. The sample included 6 residents and 1 closed record review. Based on record review, interview, and observation for 1 (456) of 6 residents	S3155		

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sample, the administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary Health Care Services (HCS) to meet the needs for resident #456 in accordance with the Functional Capacity Screening (FCS) and Negotiated Service Agreement (NSA) regarding the use of a bed assistive device.

Findings include:

- Record review for resident #456 revealed an admission dated of 1/25/13 with diagnoses Dementia, Depression, and Hypertension.

The annual FCS dated 1/31/19 recorded resident unable to assist with bathing, dressing, toileting, transfer, walking/mobility, incontinence, experienced short-term memory loss, poor memory recall, long-term memory loss, decision making, impaired decision making, and falls/unsteadiness.

The NSA and HCS dated 1/31/19 recorded resident required one staff extensive assist during showers, dressing, toileting, two person assist for transfer/mobility as needed, and transfer to wheelchair. Resident is at risk for falls, wear gripper socks when in bed, staff to use gait belt at all times and to use wheelchair for toileting at night time.

The record lacked an assessment to verify the bed assistive device was not a restraint, the resident used the bed assistive device safely and the bed assistive device design/attachment/gaps and mechanisms were safe.

The FDA (food and drug administration) Hospital bed System Dimensional and Assessment

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S3155	Continued From page 7 Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and 3/4 inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches Observation on 6/20/19 at 4:00 p.m. revealed half side rail assistive device on both sides of the bed. Interview on 6/24/19 at 10:43 p.m. with licensed nurse A stated and confirmed the resident had bed assistive device for positioning and record lacked an assessment of resident's need for assistive device or safety of the device. For resident #456, the administrator failed to ensure the licensed nurse provided or coordinated the provision of necessary HCS to meet the needs for resident #456 in accordance with the FCS and NSA regarding the use of a bed assistive device.	S3155		
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 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-105 (f) (11) The facility identified a census of 72 residents. The sample included 6 residents and 1 focus review. Based on record review, interview, and observation for 1 (#852) of 1 focus record review, the administrator failed to ensure each record contained 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. Findings included: - Record review for resident #852 revealed an admit date of 6/11/19 with diagnoses Ulcerative Colitis, Reflux, and Macular Degeneration. The Functional Capacity Screen dated 6/11/19 recorded resident independent with dressing, toileting, transfer, walking/mobility, required supervision with bathing and incontinence. Resident was not identified with cognitive deficit and had no falls in last 6 months. The Negotiated Service Agreement/Health Care Service dated 6/11/19 recorded resident independent with bathing, dressing, transfers, toileting, mobility, and decision making. Interview on 6/25/19 at 9:35 a.m. with licensed nurse A stated had an elopement over the weekend. At 11:10 a.m. licensed nurse A stated on 6/22/19 at approximately 4:08 p.m. (resident #852) was going to meet family downstairs to go out for dinner. Resident went outside to look for	S3261		

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S3261	Continued From page 9 family and kept walking with walker. At 4:45 p.m. Licensed nurse G received a call from the police department asking if a resident was missing. Resident informed police he/she lived at facility. Licensed nurse G stated yes and he/she lived here. At 5:00 p.m. the police brought resident back to facility. Family at facility to meet resident. Licensed nurse A stated has not completed investigation or reported elopement to Department yet. On 6/25/19 at 9:45 a.m. observed the nurses notes lacked documentation of resident elopement from facility on 6/22/19. Interview on 6/25/19 at 9:55 a.m. with Licensed nurse A stated and confirmed he/she instructed nurses not to document anything and he/she would when investigation of elopement completed. For resident #852, the administrator failed to ensure record contained 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		