Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011011	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE MEMORY CARE UNIT	315 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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 a resurvey with a complaint (#140035) at the above named assisted living facility conducted on 4-24,25,29-2019.	S 000		
S3155 SS=E	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 26-42-204 (a) The facility reported a census of 13 residents. The sample included 3 residents. Based on observation, interview and record review operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 2 (#100 and #200) of 3 residents who experienced falls. Findings included: - Review of resident #100's record revealed he/she admitted to the facility on 10-3-18 with diagnoses of psychosis, depression, insomnia, dementia with behavioral disturbance, hallucinations and wandering.	S3155		

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

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S3155	Continued From page 1 Review of the functional capacity screen dated 10-3-18 revealed the resident required physical assistance of staff for bathing, dressing, and toileting. The resident could walk/be mobile and transfer independently. The resident also had problems with short term memory and decision-making ability. Review of the negotiated service agreement (NSA) dated 10-3-18 directed staff to provide physical assistance with bathing, dressing, and toileting and identified the resident as independent with transfers. It also directed staff that supervision was needed for mild short-term memory loss and that the resident lacked memory recall. On 11-2-18 licensed nursing staff C amended the NSA to include the resident had a fall and staff needed to toilet the resident at 5:00 AM. Review of the nurse's notes (NN) revealed the following: NN 11-2-18 at 5:35 AM certified staff called licensed nursing staff C to report the resident on the floor. Licensed nurse C checked on the resident and noted to remind the resident not to get up by him/herself and to toilet the resident at 5:00 AM. NN 3-28-19 at 9:25 AM certified staff called licensed nursing staff C to report resident on the floor. Licensed nurse C documented for staff to continue to remind the resident if unsteady on his/her feet to sit down and rest. NN 4-1-19 at 7:30 AM certified staff D documented he/she observed the resident sitting on the floor in his/her room. Staff D documented	S3155		

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the nurse came to check on the resident and staff were to remind the resident to ask for help at all times.

NN 4-1-19 at 7:30 AM licensed nursing staff C documented his/her assessment of the fall and told staff if the resident was leaning over to have resident rest for a while.

Review of the resident's record lacked evidence of investigation of all 3 falls to identify possible root cause of the fall and interventions to decrease the risk of further falls.

During an interview on 4-25-19 at 10:57 AM licensed nursing staff C reported he/she did not really do an investigation of the falls and just thought the resident was probably trying to go to the bathroom on 11-2-18 and just fell while walking. Staff C stated due to cognitive impairment the resident would not remember if staff reminded her to do something.

- Review of resident #200's medical record revealed the resident admitted to the facility on 3-31-17 with diagnoses of dementia, diabetes, hypertension, malnutrition, and hallucinations.

Review of the significant change functional capacity screen dated 3-7-19 revealed the resident was unable to perform ALL activities of daily living except eating which he/she required physical assistance of staff to complete task. The functional capacity screen identified the resident had a problem of falls/unsteadiness and impaired decision making. The resident also had recall and long/short term memory deficit.

Review of the negotiated service agreement dated 3-7-19 identified staff needed to transfer

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the resident with 2 people for safety and comfort although 1 staff could transfer the resident in an emergency. It identified the resident lacked memory recall and staff needed to supervise the resident in all areas of care and the resident was confused as to person, place and time. Intervention from 7-2-17 for staff to check resident every 2 hours was not included in the service agreement.

Review of the amended negotiated service plan dated 7-2-17 revealed at 6:40 AM staff found the resident on the floor and went to the emergency department. Returned with no new orders and staff will continue to check the resident every 2 hours.

Review of the resident's nurses notes (NN) revealed the following:
NN 7-2-17 at 6:40 AM certified staff noted he/she heard the resident call out and found him/her on the floor by the bathroom. Staff spoke with licensed nurse and ambulance called due to hip pain.

NN 7-2-17 the licensed nursing staff C noted the resident fell and complained of right hip and leg pain. Staff C sent resident to local emergency room by ambulance.

NN 7-2-17 at 11:45 resident returned to the facility with no new orders.

NN 1-25-18 at 10:25 AM resident observed on floor by certified staff D, licensed nurse notified. Staff D noted the resident unsteady on feet and walker no beside the resident. Staff noted to remind the resident to keep walker by him/her at all times and to ask for help.

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NN 1-25-18 at 10:26 AM licensed nursing staff C noted the resident had a skin tear on right elbow and the resident stated he/she got up and was hungry. Intervention to remind resident not to get up by him/herself and use the walker.

NN 9-8-18 at 1:30 AM certified staff that the nursing assistant called the medication aide to the memory care facility and observed the resident on the mat on floor beside his/her bed. Staff contacted the licensed nursing staff C and assessment completed with certified staff on the phone. The resident stated he/she was playing with the kids and fell but did not hurt anywhere. Instructed resident not to get up out of bed without assistance and to ask for help.

NN 9-8-18 at 5:30 AM the licensed nurse noted the resident did not have any red marks or bruises and directed staff to take resident to the rest room at 1:00 AM due to resident being wet at 1:30 AM. The nurse noted the resident had a mat on the floor beside the bed for safety and a body alarm on which sounded at the time of the fall.

NN 9-18-18 at 7:20 AM licensed nursing staff C noted the medical provider in the facility to check on resident from fall on 9-8-18 and the provider stated the resident would not be a surgical candidate. Staff will continue to monitor the resident every 2 hours, matt on the floor and monitor alarm is on.

NN 9-20-18 at 9:00 AM licensed nursing staff C noted the resident still not wanting to ambulate and picks up his/her legs during transfer.

Review of the physician's progress noted dated 9-18-19 revealed the provider saw the resident after having a fall. Nursing staff note intermittent

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refusal to ambulate and the resident said "ow" every time his/her legs are touched. Symptoms very inconsistent. It also noted the resident would not be a surgical candidate and to continue fall precautions and safety measures.

Review of the medical record and nurse's notes lacked a licensed nursing assessment for injuries or change in status between 9-8-18 and 9-18-18 when resident no longer would stand for transfers. The record also lacked investigation for all 3 falls as to appropriate interventions to decrease risk of falls and injuries.

Observation on 4-24-19 at 4:10 PM certified staff F and certified staff D went into the resident's room to get the resident up for supper. The resident had been incontinent of bowel and bladder, staff provided incontinent care appropriately. Staff D had the resident's legs and staff B the residents back and staff assisted the resident to a seated position on the side of the bed. Staff then put on a gait belt and transferred the resident from the bed to his/her wheelchair. During the transfer the resident's knees were bent and his/her feet did not touch the floor. The resident resisted cares but did not speak out or act as if in any pain.

During an interview on 4-25-19 at 8:45 AM licensed nursing staff C reported he/she did not think the resident was sent out for x-rays because family did not want her to go since he/she was not a surgical candidate. Staff C confirmed he/she should have assessed the resident since he/she had a change in status and that reminding the resident to call for help would not be an appropriate intervention.

The operator failed to ensure a licensed nurse

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S3155	Continued From page 6 provided or coordinated the necessary health care services to reduce falls by the failure to thoroughly investigate the root cause of fall and implement appropriate measures to reduce the risk for further falls.	S3155		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 13 residents. The sample included 3 residents. Based on interview and record review for 1 (#200) of 3 residents the operator failed to ensure all health care services were provided by qualified staff in accordance with acceptable standards of practice. Findings included: - Review of resident #200's medical record revealed the resident admitted to the facility on 3-31-17 with diagnoses of dementia, diabetes, hypertension, malnutrition, and hallucinations. Review of the significant change functional capacity screen dated 3-7-19 revealed the resident was unable to perform ALL activities of daily living except eating which he/she required physical assistance of staff to complete task. The	S3171		

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functional capacity screen identified the resident had a problem of falls/unsteadiness and impaired decision making. The resident also had recall and long/short term memory deficit.

Review of the negotiated service agreement dated 3-7-19 identified staff needed to transfer the resident with 2 people for safety and comfort although 1 staff could transfer the resident in an emergency. It identified the resident lacked memory recall and staff needed to supervise the resident in all areas of care and the resident was confused as to person, place and time. Intervention from 7-2-17 for staff to check resident every 2 hours was not included in the service agreement.

Review of the amended negotiated service plan dated 7-2-17 revealed at 6:40 AM staff found the resident on the floor and went to the emergency department. Returned with no new orders and staff will continue to check the resident every 2 hours.

Review of the resident's nurse's notes (NN) and September 2018 medication administration record (MAR) revealed:

NN on 9-8-18 at 1:30 AM documented the nursing assistant called the medication aide to the memory care facility and observed the resident on the mat on floor beside his/her bed. Staff contacted the licensed nursing staff C and assessment completed with certified staff on the phone. The resident stated he/she was playing with the kids and fell but did not hurt anywhere. Instructed resident not to get up out of bed without assistance and to ask for help.

NN on 9-8-18 at 5:30 AM the licensed nurse

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S3171	Continued From page 8	S3171		

documented the resident checked for injuries and did not have any red marks or bruises and directed staff to take resident to the rest room at 1:00 AM due to resident being wet at 1:30 AM. The nurse noted the resident had a mat on the floor beside the bed for safety. Staff needed to continue to remind resident not to get up on his/her own and to wear a body alarm on which sounded at the time of the fall.

MAR 9-18-18 documented the resident received Tylenol twice related to pain.

MAR 9-11-18 documented the resident received Tylenol 1 time.

MAR 9-15-18 documented at 4:45 PM staff gave the resident Tylenol and Haldol for anxiety at the same time.

The nurse's notes lacked documentation of an assessment by the nurse of symptoms that required administration of this antipsychotic medication.

MAR 9-16-18 at 1:00 AM documented staff gave the resident Tylenol for leg pain and Haldol for restlessness and at 8:00 AM that resident #200 medications were not administered due to resident being very tired and not able to wake up.

The nurse's notes lacked documentation of an assessment by the nurse of symptoms that required administration of this antipsychotic medication, lacked follow up assessment and lacked documentation the medical care provider was notified of the resident's increased need for antipsychotic medication. (Note: resident #200's record documented the as needed Haldol had not been administered from 6-2-18 through 9 14-18)

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S3171	Continued From page 9 NN 9-18-18 at 7:20 AM licensed nursing staff C noted the medical provider in the facility to check on resident from fall on 9-8-18 and the provider stated the resident would not be a surgical candidate. Staff will continue to monitor the resident every 2 hours, mat on the floor and monitor alarm is on. NN 9-20-18 at 9:00 AM licensed nursing staff C noted the resident still not wanting to ambulate and picks up his/her legs during transfer. The record lacked any follow up assessment related to the changes in the resident status. During an interview on 4-25-19 at 8:45 AM licensed nursing staff C confirmed he/she should have assessed the resident since he/she had a change in status. The operator failed to ensure all health care services were provided by qualified staff in accordance with acceptable standards of practice when the licensed nurse failed to assess resident #200 following a change in condition.	S3171		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.	S3299		

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S3299	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR26-41-206(e) The facility reported a census of 13 residents. Based on observation and interview the facility failed to store all food under safe and sanitary conditions. Findings included: - Observations on 4-24-19 at 11:45 AM revealed refrigerator # 1 with an open package of deli turkey on the bottom wire rack with spillage of liquid on the same shelf. Freezer #6 contained multiple baggies of foods which included a baggie of egg noodles that was dated 4-3 with a large amount of ice build up inside of the baggie. The freezer also had excess of 1-3 inches of ice build up on the top shelving with smaller amounts built up on all of the shelves. Freezer #2 had a baggie labeled chuck roast dated 8-15 with ice in the baggie and discoloration of the meet indicating freezer burn. During an interview on 4-24-19 at 11:48 AM dietary staff A removed the pork roast from the freezer and confirmed freezer #6 needed to be defrosted. The administrator failed to ensure designated staff stored all food under safe and sanitary conditions.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control	S3305		

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S3305	Continued From page 11 (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(a)	S3305		

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S3305	Continued From page 12 The facility reported a census of 13 residents. Based on observation and interviews for all residents the operator failed to ensure designated staff provided a safe, sanitary and comfortable environment for residents. Findings included: - During initial tour of the facility on 4-24-19 at 11:40 AM with operator B revealed the ice scoop was on top of the ice machine in a plastic container without a lid. The container had brown debri in the bottom of it and operator B handed the scoop and container to the dietary staff to wash. For all residents, the operator failed to ensure staff provided a safe, sanitary, and comfortable environment for residents.	S3305		