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	B001001	A. BUILDING: _____ B. WING _____	04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND MEADOWS, LLC	1727 OREGON ROAD IOLA, KS 66749

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey and complaint investigation #139512 for the above named facility conducted on 4/01/19, 4/02/19 and 4/03/19.	S 000		
S5028 SS=D	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S5028		

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

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S5028	Continued From page 1 KAR 26-42-101 (f) The facility reported a census of 11 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to report an unwitnessed fall with injury, thoroughly investigate to rule out neglect of necessary services and take immediate measures to prevent further neglect regarding resident #466's fall on 3/21/19. Findings included: - Record review for resident #466 revealed an admission date of 11/01/17 with a readmission on 1/28/19. He/she had diagnoses of Alzheimer's dementia with behavioral disturbances, orthostatic hypertension, anemia, major depressive disorder (recurrent), psychotic disorder with delusions, restlessness, agitation, anxiety, atrial fibrillation and coronary artery disease. The significant change/readmission functional capacity screen dated 1/28/19 indicated the resident had short-term and long-term memory deficit, impaired memory recall and decision making. He/she required physical assistance from staff for all activities of daily living with a risk for falls. Review of the negotiated service agreement/health service plan (NSA/HSP) dated 1/28/19 directed staff to provide assistance of 1 staff for all activities of daily living, ambulate with a front wheeled walker using a gait belt to steady. Staff should provide verbal directions on which direction he/she should ambulate. He/she should wear a personal body alarm while in the recliner, chair or bed to notify staff he/she was moving.	S5028		

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S5028	Continued From page 2 The NSA/HSP lacked a revision following the fall on 3/21/19 to reduce the risk of further falls. Review of the nursing notes revealed certified staff A wrote on 3/21/19 at 1:07 PM - at approximately 9:00 AM staff heard the resident yelling "hey". Staff found the resident in his/her room on the floor leaning up against his/her bed. His/her left elbow had a pretty big skin tear and the right had a small skin tear. Staff called the emergency medical services to transport the resident to the hospital for evaluation. Staff asked the resident what he/she was doing, and he/she said going to the bathroom. Certified staff A indicated he/she had checked on the resident at 8:30 AM and the resident was sleeping in bed. The note indicated certified staff A notified the nurse on-call. The note lacked any information into the causal factors of the fall and/or whether the staff had placed the personal alarm on the resident as planned. On 4/02/19 the surveyor requested to review the investigation of the resident's fall. Licensed nurse/operator B provided a copy of the documented nursing note by certified staff A with a handwritten notation of licensed nurse/operator B gone - staff to put walker by bed. The facility failed to have evidence of an investigation which included statements from staff, a review of the resident's environmental factors, whether staff had followed the care plan in regard to placement of the personal alarm and when the resident was last provided care/bathroom privileges. Observation on 4/02/19 at 12:17 PM revealed the resident had multiple skin tears on and around the right elbow with dark red/purple bruising and band aids covering 3 areas, the right upper arm (deltoid area) had a green fading bruise about	S5028		

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S5028	Continued From page 3	S5028		

tennis ball size, on the right lower rib cage/waist area was a dark purple bruise about 4 inches by 2.5 inches with green/yellow edges and at middle of his/her right side along the ribs was an approximate 1 inch circular blue/green bruise.

Interview on 4/02/19 at 9:55 AM certified staff A reported the resident was in bed on 3/21/19 when he/she checked on the resident around 8:30 AM. Certified staff A reported the resident liked to sleep in. He/she reported asking the resident at that time if he/she needed to use the bathroom. He/she did not know any specific intervention put in place to reduce the risk for further falls.

Interview on 4/02/19 at 11:55 certified staff C reported he/she and certified staff A were in the office area for a little bit after breakfast then when he/she went to help another resident with bathing staff A and C were in the hallway and heard resident #466 calling out. Certified staff C said the resident had taken the personal alarm off and went to the bathroom then fell on the way back striking the oxygen concentrator and then crawled over to the beds. He/she said that day the resident was really confused. He/she did not know of any additional interventions to reduce the resident's risk for falls.

Interview on 4/02/19 at 1:00 PM licensed nurse/operator B confirmed the documents provide as written above was the only documentation of the incident. He/she confirmed he/she did not complete a thorough investigation to rule out neglect of staff to provide necessary care and services to reduce the risk for the resident to fall. He/she confirmed a report was not made to the state agency. He/she confirmed the NSA/HSP was not revised to include an intervention to reduce the risk of further falls.

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S5028	Continued From page 4 Review of the facility's undated policy titled, Incident Investigation policy and procedure revealed all incidents will be reported and investigated following company and regulatory requirements. The investigation will follow the incident investigation template format, which includes a root cause analysis and must be held in a timely manner. The operator failed to report an unwitnessed fall with injury to the state agency, thoroughly investigate to rule out neglect and take immediate measures to prevent further neglect regarding this resident's fall on 3/21/19.	S5028		
S5205 SS=F	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (a) The facility reported a census of 11 residents. Based on record review and interview the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. Findings included:	S5205		

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S5205	Continued From page 5 - On 4/01/19 during the entrance conference with licensed nurse/operator B revealed he/she staffed the overnight shift with only 1 staff member. The resident roster provided on 4/01/19 identified 4 residents with cognitive impairment. Record review on 4/021/19 at 2:55 PM of the facility's documentation for the annual evacuation drill dated 9/12/18 revealed 4 staff were involved in the evacuation drill. The documentation did not identify a scenario, where the residents were evacuated to and who stayed with the cognitively impaired residents. Observation on 4/01/19 at 5:00 PM certified staff A applied a gait belt to resident #466, assisted him/her to stand from a recliner and walk with front wheeled walker. Interview on 4/01/19 at 2:55 PM with licensed nurse/operator B confirmed he/she had not conducted an evacuation drill with the least amount of staff on duty to ensure sufficient staff to evacuate the resident's in the event of an emergency. The operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location.	S5205		
S5215 SS=E	26-42-104 (d) Disaster and Emergency Preparedness Education (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	S5215		

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S5215	Continued From page 6	S5215		

employment to the home ' s emergency management plan;
(2) education of each resident upon admission to the home regarding emergency procedures;
(3) quarterly review of the home ' 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 26-42-104 (d)(3)

The facility reported a census of 11 residents. Based on interview and record review the operator failed to ensure residents and staff had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan with residents and staff.

Findings included:

- Record review of the facility's emergency management plan revealed the policy and procedure included the 9 elements required per state regulation.

On 4/01/19 at 2:55 PM licensed nurse/operator B provided documentation of the emergency management plan review with residents and staff as follows:
8/28/17 with residents and staff
The documentation lacked evidence of a review for the 4th quarter of 2017 with the next review on

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S5215	Continued From page 7 2/05/18. 2/05/18 with residents only 5/08/18 with residents only 6/08/18 with 8 residents and 5 employees (a current employee list provided on 4/02/19 included 18 employees) 8/06/18 with 6 employees 9/12/18 with 8 residents and 7 employees The documentation lacked evidence of a review for the 4th quarter of 2018 with the next review on 1/04/19. 1/04/19 with 6 residents and 9 employees Interview on 4/01/19 at 2:55 PM with licensed nurse/operator B confirmed the lack of a quarterly review with all residents and staff on the facility's emergency/disaster plan. The operator failed to ensure residents had disaster and emergency preparedness by a failure to conduct a quarterly review of the facility's emergency management plan with residents.	S5215		
S5251 SS=D	26-42-105 (f) (11) Resident Records 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. This REQUIREMENT is not met as evidenced by: KAR 26-42-105 (f)(11)	S5251		

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S5251	Continued From page 8 The facility reported a census of 11 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure 1 of 3 resident's (#466) record had 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 #466 revealed an admission date of 11/01/17 with a readmission on 1/28/19. He/she had diagnoses of Alzheimer's dementia with behavioral disturbances, orthostatic hypertension, anemia, major depressive disorder (recurrent), psychotic disorder with delusions, restlessness, agitation, anxiety, atrial fibrillation and coronary artery disease. The significant change/readmission functional capacity screen dated 1/28/19 indicated the resident had short-term and long-term memory deficit, impaired memory recall and decision making. He/she required physical assistance from staff for all activities of daily living with a risk for falls. Review of the negotiated service agreement/health service plan (NSA/HSP) dated 1/28/19 directed staff to provide assistance of 1 staff for all activities of daily living, ambulate with a front wheeled walker using a gait belt to steady. Staff should provide verbal directions on which direction he/she should ambulate. He/she should wear a personal body alarm while in the recliner, chair or bed to notify staff he/she was moving.	S5251		

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S5251	Continued From page 9	S5251		

Review of the nursing notes revealed certified staff A wrote on 3/21/19 at 1:07 PM - at approximately 9:00 AM staff heard the resident yelling "hey". Staff found the resident in his/her room on the floor leaning up against his/her bed. His/her left elbow had a pretty big skin tear and the right had a small skin tear. Staff called the emergency medical services to transport the resident to the hospital for evaluation. The note indicated certified staff A notified the nurse on-call. At 12:15 PM the resident returned with both arms wrapped in bandages and orders to change the bandages twice a day until fully healed.

The next note dated 3/21/19 at 6:50 PM by licensed nurse D - dressing to bilateral arms are dry and intact, awaiting orders for wound care. The note lacked any information about a head to toe assessment of the resident's skin for injury.
3/21/19 at 10:38 PM received orders for bilateral elbow wounds related to fall for daily wound care and bandage changes. Bandages remain clean, dry and intact. The note lacked any other skin assessment.

The next note dated 3/24/19 at 1:34 PM note sent to physician about the resident's fall and wound care ...
3/24/19 8:02 PM dressing change performed to bilateral elbows ... no sign of infections ... the note lacked any other skin assessment.

The next note and last note in the record as of 4/01/19 at 4:00 PM was dated 3/29/19 at 3:09 PM resident has 2 shearing areas to right and left buttocks ... dressing changed to bilateral elbows ... the note had no other skin assessments.

An interview on 4/02/19 at 11:55 AM with certified

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staff C revealed he/she found a bruise on the resident's upper right arm a couple days after the fall and communicated this to a co-worker, the nurse on-call and recorded it in the shift to shift book.

Review of the shift to shift communication book on 4/02/19 at 12:10 PM with licensed nurse/operator B revealed an entry on 3/25/19 for the 7:00 AM to 4:00 PM shift - large bruise right upper arm. He/she reported no knowledge of the bruising until this morning when the staff alerted him/her after bathing the resident.

Observation on 4/02/19 at 12:17 PM revealed the resident had multiple skin tears on and around the right elbow with dark red/purple bruising and band aids covering 3 areas, the right upper arm (deltoid area) had a green fading bruise about tennis ball size, on the right lower rib cage/waist area was a dark purple bruise about 4 inches by 2.5 inches with green/yellow edges and at middle of his/her right side along the ribs was an approximate 1 inch circular blue/green bruise.

Interview on 4/02/19 at 12:20 PM with licensed nurse/operator B reported when he/she changed the dressing on 3/29/19 he/she only raised the resident's shirt enough to expose the elbow bandages. He/she confirmed the record lacked information about skin assessments or evaluation of the bruising reported on 3/25/19 by certified staff C to licensed nurse D. He/she confirmed the resident received a medication which had a risk of increased bleeding and needed monitoring for bleeding.

The operator failed to ensure this resident's record had documentation of all incidents, symptoms, and other indications of illness or

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S5251	Continued From page 11 injury including the date, time of occurrence, action taken, and results of the action.	S5251		
S5265 SS=D	26-42-205 (a) (1) Medication Self Administration Assessment (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (a) The facility reported a census of 11 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure resident #472 could safely self-administer over the counter medications he/she had in his/her room. Findings included:	S5265		

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S5265	Continued From page 12 - Record review for resident #472 revealed an admission date of 10/17/16 with a readmission on 12/20/18. He/she had diagnoses of coronary artery disease, coronary artery bypass graft with stents, hypertension, peripheral vascular disease, neuropathy, chronic cellulitis, edema, spinal stenosis, cancer, hypothyroidism and osteoarthritis. The significant change/readmission functional capacity screen dated 12/20/18 indicated the resident had some memory recall deficit, needed physical assistance with medications and treatments. The negotiated service agreement/health service plan (NSA/HSP) dated 12/20/18 directed staff to order the residents medications and treatments from a named pharmacy, certified or licensed staff administer medications to the resident. The record lacked a reassessment for self-administration of medications upon readmission with the last assessment dated 9/24/18. The 9/24/18 assessment indicated the resident was not safe to administer his/her own medications. Interview on 4/02/19 at 12:55 PM with the resident revealed he/she had Tylenol bottle in his/her room and he/she reported taking it when needed. Observation at this time, revealed the resident removed a bottle of extra strength over the counter Tylenol from a clear plastic storage drawer and a tube of petroleum jelly. He/she reported applying the petroleum jelly to his/her legs. On the table where the TV sat was a bottle of over the counter I-caps vitamins.	S5265		

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S5265	Continued From page 13 Interview on 4/02/19 at 1:00 PM with licensed nurse/operator B confirmed the resident did not get a reassessment for his/her ability to manage his/her own medications. The operator failed to ensure this resident could safely self-administer over the counter medications he/she had in his/her room.	S5265		