Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087048	A. BUILDING: _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUCER ESTATES LLC	10550 E 21ST STREET NORTH WICHITA, KS 67206

(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 an abbreviated survey for investigation of complaint #139806 of the above assisted living facility on 4/9/19 and 4/11/19.	S 000		
S3028 SS=E	26-41-101 (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 facility 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	S3028		

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

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S3028	Continued From page 1 by: KAR 26-41-101(f)(3)(C) The facility reported a census of 52 residents. The sample included 3 residents. Based on record review and interview for 1 (#2) of 3 residents sampled, the administrator failed to ensure each potential allegation of neglect was reported to the department within 24 hours of the incident and failed to thoroughly investigate each incident to rule out staff neglect of resident. Findings included: - Record review for resident #2 revealed an admission date of 9/30/18 with diagnoses of Alzheimer's disease and chronic renal insufficiency. Significant change functional capacity screen (FCS) dated 11/27/18 and significant change FCS dated 1/24/19 each indicated resident required physical assistance with toileting; supervision when transferring and walking; experienced impaired short-term memory, long-term memory, memory recall, and decision making. The FCS dated 1/24/19 indicated resident was at risk for falls. The FCS dated 11/27/18 indicated resident utilized a walker as a mobility device and did not indicate resident was at risk for falls. Negotiated service agreement/health care service plan (NSA/HCSP) dated 11/27/18 contained handwritten information dated 12/16/18 that resident was sent to emergency department for evaluation and staff to remind resident to have staff assist with activities of daily living. The 11/27/18 NSA/HCSP documented staff to assist resident with toileting according to schedule, needs, and request. On 1/7/19 a licensed nurse	S3028		

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S3028	Continued From page 2	S3028		

added an intervention of staff to take resident to bathroom every 2 hours to prevent falls.

NSA/HCSP dated 1/23/19 documented toileting assistance according to schedule, needs, and requests. Handwritten interventions added as follows:
1/28/19 Staff to ensure resident wears non-skid socks and shoes at all times.
1/31/19 Staff to ensure floor remains dry and free from clutter.
3/7/19 Staff to assist resident to sit and ensure resident has walker at all times.
3/16/19 Inform staff to check on resident every 15 minutes. Observe every 15 minutes pending physical therapy orders.
3/22/19 Staff to toilet resident every 2 hours routinely.

Clinical notes contained the following documentation by licensed nurses:

12/16/18 at 7:40 a.m. third shift staff reported resident supine on bathroom floor since 6:10 a.m. and unable to get resident off floor due to pain resident reported in right shoulder and both hips. Resident evaluated and assisted to wheelchair. Medical care provider ordered X-ray of right shoulder and both hips. Staff to toilet resident every 2 hours to prevent falls.

1/16/19 at 5:00 p.m. resident found on floor in room during rounds at 3:35 p.m. Quarter size skin scrape to right forehead. Intervention of chair and bed alarm. (Note: NSA/HCSP did not specify use of bed and chair alarm.)

1/28/19 at 2:15 p.m. resident had a fall at 7:10 a.m. Resident was found by door and could not remember what happened.

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S3028	Continued From page 3 1/31/19 at 11:05 a.m. Resident sitting on bathroom floor at 9:45 a.m. Resident crying and stated he/she fell. Resident to wear non-skid socks to prevent falls. 3/7/19 4:05 p.m. staff alerted nurse that resident fell when pulling chair in dining room. 3/16/19 at 1:15 p.m. third shift staff reported resident said it was dark, could not see door, and ran into doorway. Bruise and swelling to left side of forehead close to eyebrow. Ice pack applied. 3/16/19 at 5:30 p.m. Staff reported resident was in bed at 4:30 p.m. and at 4:45 p.m. staff went to bring resident to dining room and found resident on floor in front of toilet with pants to knees. Resident unsure how he/she came to be on floor. Staff to check on resident every 15 minutes. 3/22/19 at 9:40 a.m. third shift staff reported resident was sitting on floor in front of toilet with brief down to lower thighs. Resident reported pain in right hip and right lower leg. Staff to toilet resident every 2 hours routinely. During an interview at 12:15 p.m. on 4/9/19, certified staff D stated he/she checked on resident every 30 minutes when resident in his/her room. At 12:17 p.m. certified staff E, when asked about interventions to reduce resident's risk for falls, stated check on resident every 30 minutes and toilet resident every 2 to 3 hours. Certified staff E provided documentation of 30-minute checks and when resident was toileted. Certified staff E stated he/she tried to stay with resident when transferring and walked with resident.	S3028		

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S3028	Continued From page 4 During an interview at 2:07 p.m. on 4/9/19, licensed nurse C stated he/she had not reported any of the incidents to the department. Licensed nurse C stated he/she did investigate and provided surveyor with copies of the investigations for times resident was found on floor. Licensed nurse C did not investigate the resident's injury on 3/16/19 when resident reported he/she ran into door causing bruising and swelling to forehead. Each of the investigations dated 12/16/18, 1/7/19, 1/16/19, 1/28/19, 1/31/19, 3/16/19 and 3/22/19 contained information as documented about each incident as in the clinical notes and a statement of "Based on conversations with resident and with employees abuse and or neglect cannot be substantiated or has been ruled out." Each investigation lacked proof of how this determination was made, what contributed to the incident, and if staff members were providing necessary timely care to the resident to try to prevent falls and injuries. During an interview at 3:16 p.m. on 4/9/19, licensed nurse C stated he/she did obtain written statements from staff members about each incident involving a resident but if he/she did not report the incident to the department then he/she did not maintain the statements as part of the investigation. The administrator failed to ensure each potential allegation of neglect of resident #2 was reported to the department within 24 hours of the incident and failed to thoroughly investigate each incident to rule out staff neglect of resident.	S3028		