STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008008	A. BUILDING: _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF AUGUSTA	1611 FAIRWAY AUGUSTA, KS 67010

(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 an abbreviated survey with investigation of complaint #85704 of the above assisted living facility on 9/30/15 and 10/1/15.	S 000		
S3028 SS=F	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 by:	S3028		

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

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S3028	Continued From page 1 KAR 26-41-101(f)(3)(A) The facility reported a census of 42 residents. The sample included 3 residents. Based on record review, interview, and observation for 3 (#400, #500, and #600) of 3 residents sampled, the operator failed to investigate and report to the department within 24 hours when staff members found each cognitively impaired resident on the floor in order to rule out abuse and/or neglect. Findings included: - Record review for resident #400 revealed an admission date of 4/27/15 and diagnoses of dementia with behavioral disturbance, diabetes mellitus type II, and hypertension. The admission functional capacity screen dated 2/27/15 indicated the resident was independent with transferring, walking, and eating; required supervision with bathing, dressing, and toileting; required physical assistance with management of medications and treatments; experienced impaired short-term and long-term memory, decision making, and memory recall; was not at risk for falls; and did not utilize an assistive device for mobility. The negotiated service agreement and health care service plan dated 4/27/15 documented resident was independent with mobility, able to ambulate to bathroom and complete all hygiene needs independently, and alert to person only with decision-making deficits. The record contained written communication to the resident's medical care provider from licensed nurse #B dated 7/12/15 that at approximately 7:15 a.m. a certified employee found resident on	S3028		

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S3028	Continued From page 2	S3028		

floor at the foot of the resident's bed. Licensed nurse #B documented resident had a red area to his/her right knee and "Appears to have caught foot on a blanket lying near the foot of the bed."

At 3:00 p.m. on 9/30/15, observed resident sitting in a chair in commons area of the memory care unit. Resident did not respond when spoken to and moved legs and left arm constantly. Certified staff #C stated resident had declined and was transferred to the memory care unit some time ago.

At 3:55 p.m. on 9/30/15, operator stated the incident was not investigated and not reported to the department. Operator stated that "We started watching (resident) after the incident on 7/12/15 and moved resident to the memory care unit due to needing more attention and oversight."

The operator failed to investigate and report to the department within 24 hours when staff members found cognitively impaired resident #400 on the floor in order to rule out abuse and/or neglect.

- Record review for resident #500 revealed an admission date of 2/18/15 and diagnoses of senile dementia, orthostatic hypotension, vertigo, and congestive heart failure.

The admission functional capacity screen dated 2/18/15 indicated the resident required supervision with toileting; physical assistance with bathing, dressing, transferring, walking, and management of medications and treatments; experienced impaired memory recall; was at risk for falls; and used a walker or wheelchair for mobility assistance.

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S3028	Continued From page 3 The negotiated service agreement/health care service plan dated 2/18/15 documented supervision with toileting for safety, physical assistance with transferring due to fall risk, and walk with resident for safety. The negotiated service agreement/health care service plan documented the resident was alert and oriented to person, place, and time and was able to understand directions and communicate his/her needs effectively. The nurse's notes contained documentation by licensed nurse #B on 4/2/15 (no time documented) that resident was found lying on floor on left side in between night stand and bed, resident unable to recount how (resident) came to be on floor. Resident had a bruise on left arm and a bruise on right lower back. On 4/3/15 (no time documented) licensed nurse #B documented resident was found on floor in living room area of apartment and resident could not explain how (he/she) came to be on the floor. Resident was sent by ambulance to the hospital for evaluation and returned to the facility the same day with diagnosis of sinusitis. Documentation received from medical care provider after evaluation included orders for an antibiotic for sinusitis, administration of meclizine for dizziness, instruction for staff members to assist resident with ambulation to minimize fall risk, and follow-up with medical care provider for worsening dementia. During an interview at 2:45 p.m. on 9/30/15, licensed nurse #A stated he/she did not investigate the 2 incidents of staff finding resident on floor and did not report to the department.	S3028		

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S3028	Continued From page 4	S3028		

The operator failed to investigate and report to the department within 24 hours each time staff members found cognitively impaired resident #500 on the floor in order to rule out abuse and/or neglect.

- Record review for resident #600 revealed an admission date of 9/9/15 and diagnoses of dementia, atrial fibrillation, and congestive heart failure.

The admission functional capacity screen dated 9/9/15 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, mobility, eating, and management of medications and treatments; experienced impaired short-term and long-term memory, decision making, and memory recall, was not at risk for falls; and used a walker or wheelchair for mobility.

The negotiated service agreement/health care service plan documented resident had a very unsteady gait, required staff assistance with mobility using walker or wheelchair, and staff to provide physical assistance with toileting. The negotiated service agreement/health care service plan documented resident was oriented to self only, could communicate his/her needs, and sometimes understood simple directions.

At 1:25 p.m. on 9/30/15, observed resident #600 sitting in a wheelchair in the commons area of the memory care unit. Observed bruising around the resident's eyes and forehead.

The resident's record did not contain documentation of the cause of the resident's bruising of face.

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S3028	Continued From page 5 At 2:15 p.m. on 9/30/15, licensed nurse #A stated resident "Had a fall the other night." Licensed nurse #A called licensed nurse #B to find out when the fall occurred and then stated resident fell in bathroom at 2:00 a.m. on 9/26/15. Licensed nurse #A stated the incident was not investigated or reported to the department. The operator failed to investigate and report to the department within 24 hours when staff members found cognitively impaired resident #600 on the floor in order to rule out abuse and/or neglect.	S3028		
S3155 SS=F	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 reported a census of 42 residents. The sample included 3 residents. Based on record review, observation, and interview for 3 (#400, #500, and #600) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each resident.	S3155		

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S3155	Continued From page 6 Findings included: - Record review for resident #400 revealed an admission date of 4/27/15 and diagnoses of dementia with behavioral disturbance, diabetes mellitus type II, and hypertension. The admission functional capacity screen dated 2/27/15 indicated the resident was independent with transferring, walking, and eating; required supervision with bathing, dressing, and toileting; required physical assistance with management of medications and treatments; experienced impaired short-term and long-term memory, decision making, and memory recall; was not at risk for falls; and did not utilize an assistive device for mobility. The negotiated service agreement and health care service plan dated 4/27/15 documented resident was independent with mobility, able to ambulate to bathroom and complete all hygiene needs independently, and alert to person only with decision-making deficits. The record contained written communication to the resident's medical care provider from licensed nurse #B dated 7/12/15 that at approximately 7:15 a.m. a certified employee found resident on floor at the foot of the resident's bed. Licensed nurse #B documented resident had a red area to his/her right knee and "Appears to have caught foot on a blanket lying near the foot of the bed." At 3:00 p.m. on 9/30/15, observed resident sitting in a chair in commons area of the memory care unit. Resident did not respond when spoken to and moved legs and left arm constantly. Certified staff #C stated resident had declined and was	S3155		

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S3155	Continued From page 7	S3155		

transferred to the memory care unit some time ago. Certified staff #C stated resident required physical assistance with bathing, dressing, toileting, and eating and that staff members assisted resident with transferring and walking to keep resident safe. Licensed nurse #A confirmed resident experienced a change in physical functioning.

The negotiated service agreement/health care service plan lacked revision to include the health care services the resident required and to address the resident's risk for falls.

At 3:55 p.m. on 9/30/15, operator stated "We started watching (resident) after the incident on 7/12/15 and moved resident to the memory care unit due to needing more attention and oversight."

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #400 who experienced a significant change in physical functioning and was at risk for falls.

- Record review for resident #500 revealed an admission date of 2/18/15 and diagnoses of senile dementia, orthostatic hypotension, vertigo, and congestive heart failure.

The admission functional capacity screen dated 2/18/15 indicated the resident required supervision with toileting; physical assistance with bathing, dressing, transferring, walking, and management of medications and treatments; experienced impaired memory recall; was at risk for falls; and used a walker or wheelchair for mobility assistance.

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S3155	Continued From page 8 The negotiated service agreement/health care service plan dated 2/18/15 documented supervision with toileting for safety, physical assistance with transferring due to fall risk, and walk with resident for safety. The negotiated service agreement/health care service plan documented the resident was alert and oriented to person, place, and time and was able to understand directions and communicate his/her needs effectively. The negotiated service agreement/health care service plan lacked interventions to address the resident's vertigo and orthostatic hypotension. The nurse's notes contained documentation by licensed nurse #B on 4/2/15 (no time documented) that resident was found lying on floor on left side in between night stand and bed, resident unable to recount how (resident) came to be on floor. Resident had a bruise on left arm and a bruise on right lower back. On 4/3/15 (no time documented) licensed nurse #B documented resident was found on floor in living room area of apartment and resident could not explain how (he/she) came to be on the floor. Resident was sent by ambulance to the hospital for evaluation and returned to the facility the same day with diagnosis of sinusitis. Documentation received from medical care provider after evaluation included orders for an antibiotic for sinusitis, administration of meclizine for dizziness, instruction for staff members to assist resident with ambulation to minimize fall risk, and follow-up with medical care provider for worsening dementia. During an interview at 1:10 p.m. on 9/30/15, resident #500 stated he/she did experience	S3155		

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S3155	Continued From page 9	S3155		

dizziness. Resident could not remember falling and stated "They said I did." Certified employee #D came to the resident's apartment. Employee #D stated that staff gave resident food to eat when resident complained of being dizzy.

At 4:00 p.m. on 9/30/15, operator stated resident #500 experienced a fall this morning.

At 4:05 p.m. on 9/30/15 licensed nurse #A provided an incident report completed by certified staff #C that he/she found resident lying on back on living room floor of apartment at 7:15 a.m. on 9/30/15.

The negotiated service agreement/health care service plan lacked revision to include the health care services the resident required and to address the resident's risk for falls.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of resident #500 who was at risk for falls.

- Record review for resident #600 revealed an admission date of 9/9/15 and diagnoses of dementia, atrial fibrillation, and congestive heart failure.

The admission functional capacity screen dated 9/9/15 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, mobility, eating, and management of medications and treatments; experienced impaired short-term and long-term memory, decision making, and memory recall, was not at risk for falls; and used a walker or wheelchair for mobility.

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S3155	Continued From page 10	S3155		

The negotiated service agreement/health care service plan documented resident had a very unsteady gait, required staff assistance with mobility using walker or wheelchair, and staff to provide physical assistance with toileting. The negotiated service agreement/health care service plan documented resident was oriented to self only, could communicate his/her needs, and sometimes understood simple directions.

At 1:25 p.m. on 9/30/15, observed resident #600 sitting in a wheelchair in the commons area of the memory care unit. Observed bruising around the resident's eyes and forehead.

The resident's record did not contain documentation of the cause of the resident's bruising of face.

At 2:15 p.m. on 9/30/15, licensed nurse #A stated resident "Had a fall the other night." Licensed nurse #A called licensed nurse #B to find out when the fall occurred and then stated resident fell in bathroom at 2:00 a.m. on 9/26/15. Licensed nurse #A stated since the incident staff members were to check on resident, leave resident's door open, and remind resident to call for assistance. Licensed nurse #A stated staff were to provide stand-by assistance to resident when toileting. Licensed nurse #A stated "We are trying to remind (resident) to call for assistance."

The resident's negotiated service agreement/health care service plan lacked revision to ensure resident would receive assistance when toileting.

The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the

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S3155	Continued From page 11 needs of resident #600 who was at risk for falls.	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 This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 42 residents. The sample included 3 residents. Based on record review, observation, and interview for 1 (#600) of 3 residents sampled, the operator failed to ensure the residents record contained documentation of injury including the date, time of occurrence, action taken, and results of the action. Findings included: - Record review for resident #600 revealed an admission date of 9/9/15 and diagnoses of dementia, atrial fibrillation, and congestive heart failure. The admission functional capacity screen dated 9/9/15 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, mobility, eating, and management of medications and treatments; experienced impaired short-term and long-term memory,	S3261		

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S3261	Continued From page 12	S3261		

decision making, and memory recall, was not at risk for falls; and used a walker or wheelchair for mobility.

The negotiated service agreement/health care service plan documented resident had a very unsteady gait, required staff assistance with mobility using walker or wheelchair, and staff to provide physical assistance with toileting. The negotiated service agreement/health care service plan documented resident was oriented to self only, could communicate his/her needs, and sometimes understood simple directions.

At 1:25 p.m. on 9/30/15, observed resident #600 sitting in a wheelchair in the commons area of the memory care unit. Observed bruising around the resident's eyes and forehead.

The resident's record contained one entry in the nurse's notes dated 9/9/15 that documented the resident's admission to the facility. The record did not contain documentation of the cause of the resident's bruising of face including the date, time of occurrence, action taken, and results of the action.

At 2:15 p.m. on 9/30/15, licensed nurse #A stated resident "Had a fall the other night." Licensed nurse #A called licensed nurse #B to find out when the fall occurred and then stated resident fell in bathroom at 2:00 a.m. on 9/26/15. Licensed nurse #A stated a staff member called (him/her) to report the fall and he/she told the staff member to call the hospice nurse to come assess the resident. Licensed nurse #A confirmed he/she did not document the incident in the resident's record and that the record lacked documentation of follow-up assessments of the resident by licensed nurse #A or #B.

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S3261	Continued From page 13 The operator failed to ensure resident #600's record contained documentation of injury including the date, time of occurrence, action taken, and results of the action.	S3261		