STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N088003	A. BUILDING: _____ B. WING _____	03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT LIBERAL SPRINGS	1500 N TERRACE LIBERAL, KS 67901

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaints #81352 and #84932 of the above assisted living facility on 3/24/15, 3/25/15, 3/26/15, and 3/30/15.	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 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 43 residents. The sample included 4 residents and 2 closed records reviewed. Based on record review and interview for 2 (#253 and #250) of 4 residents sampled and 1 (#254) of 2 closed records reviewed, the operator failed to investigate and report to the department each time staff members found each resident on the floor in order to rule out abuse and/or neglect. Findings included: - Record review for resident #253 revealed an admission date of 10/1/07 and diagnoses of coronary artery disease and dementia. The functional capacity screen dated 4/28/14 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, transferring, and mobility; experienced impaired short-term memory, long-term memory, decision making, and memory recall; was at risk for falls and utilized a wheelchair for mobility. The negotiated services agreement/health care service plan (NSA/HCSP) dated 10/29/14 described health care services provided by facility staff members of physical assistance with dressing, toileting, transferring, and mobility per wheelchair due to unsteady gait. The NSA/HCSP documented the resident was at risk for falls and experienced periods of confusion. The Service Notes contained documentation by licensed nurse #C as follows: 11/6/13 at 8:00 a.m. Resident found on floor this a.m. No injury noted.	S3028		

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S3028	Continued From page 2 2/18/14 at 10:00 a.m. Resident found on floor. Denies injury. 4/19/14 at 1:00 p.m. Resident found on floor twice this a.m. Complained of diarrhea. Resident stated was trying to get to the bathroom. 4/20/14 at 1:00 p.m. Resident found on floor this a.m. Mentally sluggish this a.m. Refused to go to the hospital for evaluation in the emergency department. 8/9/14 at 11:00 p.m. Resident found on floor. Resident stated "was late to a PTA meeting." At 1:00 p.m. on 3/25/15, operator stated he/she did not report the above incidents to the department and did not investigate to rule out abuse and/or neglect of resident. The operator failed to investigate and report to the department each time staff members found resident #253 on the floor in order to rule out abuse and/or neglect. - Record review for resident #250 revealed an admission date of 7/8/13 and diagnoses of dementia and generalized pain. The record contained a significant change functional capacity screen dated 2/26/15 that indicated the resident was unable to perform bathing, dressing, toileting, transferring, mobility; was incontinent of urine; experienced impaired short-term memory, long-term memory, decision making, and memory recall; utilized a wheelchair for mobility; and was at risk for falls. The negotiated service agreement and health	S3028		

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S3028	Continued From page 3	S3028		

care service plan (NSA/HCSP) dated 2/26/15 documented the services of two-person physical assistance with bathing, dressing, and transferring; physical assistance with toileting; mobility per wheelchair; and "fall management every shift." The NSA/HCSP documented the resident experienced a fall 1/13/15 that resulted in a right hip fracture. The NSA/HCSP documented resident had moments of forgetfulness.

The Service Notes contained an entry by the operator at 11:30 a.m. on 1/13/15 that resident was transferred to the hospital by ambulance due to right hip pain with possible fracture. At 2:30 p.m. on 1/14/15, licensed nurse #C documented resident did well after hip surgery. The Service Notes lacked documentation prior to 1/13/15 to explain reason for right hip pain and need for hospitalization.

During an interview at 3:40 p.m. on 3/24/15, operator stated staff members found resident on the floor on 1/13/15 and "We think (resident) slid out of bed." Operator stated he/she completed a facility incident report but did not report incident to the department.

Review of the incident report provided by the operator at 4:40 p.m. on 3/24/15 documented the incident at 6:20 a.m. on 1/13/15 that staff members went to resident room to check if resident was ready for breakfast and found resident on floor. The incident report did not include a thorough investigation of how resident came to be on the floor.

The operator failed to investigate and report to the department when staff members found resident #250 on the floor in order to rule out

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S3028	Continued From page 4 abuse and/or neglect. - Record review for resident #254 revealed an admission date of 3/9/13 and a diagnosis of macular degeneration. The functional capacity screen dated 2/3/14 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; was incontinent of urine; experienced impaired short-term memory, long-term memory, decision making, and memory recall; was unsteady with walking, and used a walker to aid with mobility. The negotiated service agreement and health care service plan (NSA/HCSP) dated 8/5/14 documented resident experienced periods of confusion and forgetfulness and required reminders to find areas in the community and to find the bathroom. The NSA/HCSP documented staff members to provide physical assistance with bathing, dressing, toileting, transferring, and ambulation. The service notes contained an entry at 8:00 p.m. on 8/12/14 by licensed nurse #C that staff members found resident on floor in front of elevator. The nurse documented resident did not know why he/she was on the floor. At 11:15 a.m. on 3/25/15, the operator provided an "Event Management Report" completed by licensed nurse #C on 8/13/14 that documented the incident on 8/12/14 with the same information as documented in the Service Notes entry 8/12/14. The report lacked an investigation into how resident came to be on the floor. Operator stated he/she did not report the incident to the department.	S3028		

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S3028	Continued From page 5 The operator failed to investigate and report to the department when staff members found resident #254 on the floor in order to rule out abuse and/or neglect.	S3028		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)(3) The facility reported a census of 43 residents. The sample included 4 residents and 2 closed records reviewed. Based on record review and interview for 3 (#253, #252, and #250) of 3 residents sampled, the operator failed to ensure the development of a written negotiated service	S3085		

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S3085	Continued From page 6	S3085		

agreement (NSA) for each resident, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, the case manager, and, if agreed to by the resident or the resident's legal representative, the resident's family that included a description of the services the resident would receive; identification of the provider of the service; and identification of the party responsible for payment when outside resources provided a service.

Findings included:

- Record review for resident #253 revealed an admission date of 10/1/07 and diagnoses of coronary artery disease and dementia.

Licensed nurse #A documented in the Service Notes on 3/3/15 that resident returned to the facility from a hospital stay and to have hospice services.

The functional capacity screen dated 4/28/14 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; experienced impaired short-term memory, long-term memory, decision making, and memory recall; was at risk for falls and utilized a wheelchair for mobility.

The negotiated services agreement/health care service plan (NSA/HCSP) dated 10/29/14 described health care services to be provided by facility staff members. The NSA/HCSP lacked a description of services provided by hospice, the name of the hospice, and the party responsible for payment of the services.

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S3085	Continued From page 7 At 3:30 p.m. on 3/24/15, licensed nurse #A stated resident received hospice services of skilled nursing assessment two times a week, visits by a social worker, and medical supplies and equipment provided. Licensed nurse #A confirmed the resident's NSA lacked a description of services provided by hospice, the name of the hospice, and the party responsible for payment for the services. The operator failed to ensure the development of a written negotiated service agreement for resident #253, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, the case manager, and, if agreed to by the resident or the resident's legal representative, the resident's family that included a description of the services the resident would receive from an outside resource; identification of the provider of the service; and identification of the party responsible for payment when outside resources provided a service. - Record review for resident #250 revealed an admission date of 7/8/13 and diagnoses of dementia and generalized pain. The record contained a significant change functional capacity screen dated 2/26/15 that indicated the resident was unable to perform bathing, dressing, toileting, transferring, mobility, and management of medications and treatments; required physical assistance with eating; was incontinent of urine; experienced impaired short-term memory, long-term memory, decision making, and memory recall; utilized a wheelchair for mobility; and was at risk for falls.	S3085		

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S3085	Continued From page 8 The negotiated service agreement and health care service plan (NSA/HCSP) dated 2/26/15 documented the services of two-person physical assistance with bathing, dressing, and transferring; physical assistance with toileting; mobility per wheelchair; and "fall management every shift." The NSA/HCSP listed the name of the home health agency providing physical therapy services with a description of strengthening and post hip fracture exercises. The NSA/HCSP lacked the party responsible for payment of the outside resource. At 3:25 p.m. on 3/24/15, licensed nurse #A confirmed the resident ' s NSA lacked the party responsible for payment of physical therapy services. The operator failed to ensure the development of a written negotiated service agreement for resident #250, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, the case manager, and, if agreed to by the resident or the resident's legal representative, the resident's family that included identification of the party responsible for payment when an outside resource provided a service. - Record review for resident #252 revealed an admission date of 9/1/12 and diagnoses of diabetes mellitus and Parkinson's disease. The functional capacity screen dated 3/10/14 indicated the resident was unable to perform management of medications. The negotiated service agreement/health care	S3085		

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S3085	Continued From page 9 service plan (NSA/HCSP) dated 10/29/14 documented the resident required insulin injections and "staff will give insulin injections as directed." At 12:00 p.m. on 3/24/15, licensed nurse #A stated the licensed nurse administered the resident's insulin. The NSA/HCSP lacked documentation that specified the licensed nurse administered insulin injections to resident. The operator failed to ensure the development of a written negotiated service agreement for resident #252, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative, the case manager, and, if agreed to by the resident or the resident's legal representative, the resident's family that included identification of the provider of insulin injections.	S3085		
S3160 SS=D	26-41-204 (c) HEALTH CARE SERVICES (c) The health care services provided by or coordinated by a licensed nurse may include the following: (1) Personal care provided by direct care staff or by certified or licensed nursing staff employed by a home health agency or a hospice; (2) personal care provided gratuitously by friends or family members; and (3) supervised nursing care provided by, or under the guidance of, a licensed nurse.	S3160		

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S3160	Continued From page 10 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(c)(1)(2)(3) The facility reported a census of 43 residents. The sample included 4 residents and 2 closed records reviewed. Based on record review, observation, and interview for 1 (#252) of 4 residents sampled, the operator failed to ensure health care services were provided by or coordinated by a licensed nurse that included personal care provided by the facility's direct care staff or by certified or licensed nursing staff employed by a home health agency or a hospice; personal care provided gratuitously by friends or family members; or supervised nursing care provided by, or under the guidance of, a licensed nurse. Findings included: - Record review for resident #252 revealed an admission date of 9/1/12 and diagnoses of diabetes mellitus and Parkinson's disease. The functional capacity screen dated 3/10/14 indicated the resident was independent with transferring, walking, and eating; required physical assistance with bathing, dressing, and toileting; was unable to perform management of medications and treatments; was usually continent of urine; did not experience impaired cognition; and used a walker for mobility assistance. The negotiated service agreement and health care service plan (NSA/HCSP) dated 10/29/14 indicated the resident had a history of falls. The	S3160		

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S3160	Continued From page 11 NSA/HCSP documented facility direct care staff provided stand-by assistance with bathing and administration of medications. The NSA/HCSP documented resident had a 24 hour attendant that provided physical assistance with dressing, toileting, personal hygiene, transferring, and mobility. The NSA/HCSP lacked documentation that the attendant was supervised by a licensed nurse or that the services were provided gratuitously by friends or family members The service notes contained documentation by licensed nurse #C as follows: 9/24/14 at 2:15 p.m. Resident found on floor after staff offered to assist resident to bathroom. Resident had refused assistance and got up to bathroom after staff left the room. Spoke with family member about a possible sitter for resident since resident is non-compliant. 10/2/14 at 3:30 p.m. Resident found on floor by closet. Resident stated (he/she) did not fall. Family member given list of sitters. 10/19/14 at 11:00 a.m. Resident found on floor in kitchen area. Resident stated did not fall. 10/19/14 at 4:00 p.m. Family friend came down at 3:00 p.m. and reported resident on floor by recliner. Resident stated he/she was reaching for something and slid out of recliner. Resident stated he/she could not afford sitters and "promises to behave." 10/21/14 at 11:00 a.m. Doing well with sitters. 10/29/14 at 6:00 p.m. Resident care plan meeting at 4:00 p.m. Level of care reduced to level 2 as resident had personal attendants at this time.	S3160		

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S3160	Continued From page 12 11/14/14 at 4:00 p.m. Family's attendants doing well. 12/4/14 at 2:00 p.m. Resident doing well with caregivers. At 2:55 p.m. on 3/24/15, met resident #252 in the resident's apartment. A person in the apartment introduced self as the resident's private caregiver and stated he/she assisted resident with toileting. The private caregiver stated he/she provided care to the resident as instructed by the resident's family member and was not supervised by a licensed nurse. During an interview at 3:45 p.m. on 3/24/15, the operator stated resident kept falling and would not call for facility staff assistance when needed. Operator stated family member hired private duty caregivers to be with resident 24 hours a day to prevent falls. At 4:30 p.m. on 3/24/15, certified staff member #B "Don't do much (for resident) unless caregiver calls." The operator failed to ensure that health care services for resident #252 were provided by or coordinated by a licensed nurse that included personal care provided by the facility's direct care staff or by certified or licensed nursing staff employed by a home health agency or a hospice; personal care provided gratuitously by friends or family members; or supervised nursing care provided by, or under the guidance of, a licensed nurse.	S3160		

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S3261	Continued From page 13	S3261		
S3261 SS=E	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 26-41-(105)(f)(11) The facility reported a census of 43 residents. The sample included 4 residents and 2 closed records reviewed. Based on record review and interview for 2 (#250 and #252) and 1 (#255) of 2 closed records reviewed, the operator failed to ensure the resident's 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 #250 revealed an admission date of 7/8/13 and diagnoses of dementia and generalized pain. The record contained a significant change functional capacity screen dated 2/26/15 that indicated the resident was unable to perform bathing, dressing, toileting, transferring, mobility, and management of medications and treatments; required physical assistance with eating; was incontinent of urine; experienced impaired short-term memory, long-term memory, decision	S3261		

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EMERITUS AT LIBERAL SPRINGS	1500 N TERRACE LIBERAL, KS 67901

(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
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making, and memory recall; utilized a wheelchair for mobility; and was at risk for falls.

The negotiated service agreement and health care service plan (NSA/HCSP) dated 2/26/15 documented the services of two-person physical assistance with bathing, dressing, and transferring; physical assistance with toileting; mobility per wheelchair; and "fall management every shift."

The service notes contained an entry by the operator at 11:30 a.m. on 1/13/15 that resident was transported to hospital by ambulance due to right hip pain and possible fracture. At 2:30 p.m. on 1/14/15, licensed nurse #C documented family member stated resident did well after hip surgery. The service notes lacked an entry of an incident or indications of injury for the cause of the hip pain and diagnoses of a hip fracture.

At 3:40 p.m. on 3/24/15, the operator stated staff member found resident on the floor (1/13/15) and apparently resident slid out of bed. Operator confirmed the resident's record lacked documentation of staff member finding resident on the floor.

The operator failed to ensure resident #250's record contained documentation of an incident with injury including the date, time of occurrence, action taken, and results of the action.

- Record review for resident #252 revealed an admission date of 9/1/12 and diagnoses of diabetes mellitus and Parkinson's disease.

The functional capacity screen dated 3/10/14 indicated the resident was independent with transferring, walking, and eating; required

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	N088003	A. BUILDING: _____ B. WING _____	03/30/2015

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physical assistance with bathing, dressing, and toileting; was unable to perform management of medications and treatments; was usually continent of urine; did not experience impaired cognition; and used a walker for mobility assistance.

The negotiated service agreement and health care service plan (NSA/HCSP) dated 10/29/14 indicated the resident had a history of falls. The NSA/HCSP documented facility direct care staff provided stand-by assistance with bathing and administration of medications. The NSA/HCSP documented resident had a 24 hour attendant that provided physical assistance with dressing, toileting, personal hygiene, transferring, and mobility.

At 2:55 p.m. on 3/24/15, met resident #252 in the resident's apartment. A person in the apartment introduced self as the resident's private caregiver and stated he/she assisted resident with toileting. When resident was asked about recent falls, the private caregiver stated he/she was told by another private caregiver that resident slid out of bed recently.

Review of the service notes (documentation by licensed nurse) revealed the latest entry dated 12/4/14 at 2:00 p.m. by licensed nurse #C of "Resident doing well with caregivers."

During an interview at 12:45 p.m. on 3/25/15, licensed nurse #A stated resident was without a private caregiver from 10:00 p.m. until 12:20 a.m. 2 nights ago when facility staff found resident on the floor at midnight. Licensed nurse #A stated the staff member called him/her report the resident's vital signs to the nurse and resident did not complain of pain. Licensed nurse #A stated

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S3261	Continued From page 16	S3261		

he/she instructed the staff member to assist resident back to bed. Licensed nurse #A confirmed the resident ' s record lacked documentation of the incident including the date, time of occurrence, action taken, and results of the action.

The operator failed to ensure resident #252's record contained documentation of an incident including the date, time of occurrence, action taken, and results of the action.

- Review of the list of residents dismissed since 11/1/14 revealed resident #255 died at the facility.

Closed record review for resident #255 revealed an admission date of 10/20/14 and diagnosis of Alzheimer's dementia.

The record lacked a functional capacity screen.

The negotiated service agreement and health care service plan (NSA/HCSP) dated 10/20/14 documented facility staff to provide physical assistance with bathing; two-person physical assistance with transferring, dressing, and mobility; management of medications and treatments; and encouragement to eat. The NSA/HCSP documented hospice services to coordinate schedule and needs with family and physician.

The last entry in the service notes (documentation by licensed nurses) was by licensed nurse #D at 12:30 p.m. on 12/9/14 of attempts to feed applesauce unsuccessful, water taken, incontinence care provided, pressure ulcer to lower left cheek, and resident repositioned. The service notes lacked documentation of the resident's death.

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S3261	Continued From page 17 The record contained a form used by hospice staff to document date, name of hospice staff, and reason for visit. The last entry on the form was dated 12/29/14 with name of a hospice licensed nurse and reason for visit as "death call." At 2:05 p.m. on 3/25/15, the operator confirmed the resident's record lacked documentation by the facility licensed nurse that the resident died including the date and time. The operator failed to ensure resident #255's record contained documentation of the resident's death including the date and time of occurrence.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (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 employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' 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	S3280		

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S3280	Continued From page 18 by: KAR 26-41-104(d)(3) The facility reported a census of 43 residents. The sample included 4 residents and 2 closed records reviewed. Based on interview for all residents and all employees, the operator failed to ensure the performance of a quarterly review of the facility's emergency management plan with employees and residents Findings included: - At 9:55 a.m. on 3/24/15, the operator stated residents received information on admission regarding the facility's emergency management plan and employees and residents participated in emergency evacuation drills. Operator stated residents and employees did not receive a quarterly review of the entire emergency plan. For all residents and all employees, the operator failed to ensure the performance of a quarterly review of the facility's emergency management plan with employees and residents	S3280		