STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 W 119TH STREET OLATHE, KS 66061

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 10/03/22.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 49 residents. The sample included 15 residents. Based on observation, record review and interview the facility failed to secure chemicals in a safe, locked area, and out of reach of the 13 cognitively impaired independently mobile residents. This placed the affected residents at risk for accidents. Findings Included: - On 09/21/22 at 07:10AM an observation of the secured memory care unit revealed an unlocked sink cabinet in the kitchenette area accessible to the dementia care (progressive mental disorder characterized by failing memory, confusion) residents. Further investigation revealed two quart-size bottles which contained bleach disinfectant. The label stated, "keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed."	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/03/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 On 09/22/22 at 07:30AM an inspection of the sink cabinet revealed the door to be secured. Licensed Nurse (LN) H stated that staff should be checking the cabinets and drawers daily before and after meal services to ensure they were locked. In an interview on 09/27/22 at 02:30PM Licensed Nurse (LN) G identified that hazardous chemicals should always be secured in a locked area and not accessible to the residents. In an interview on 09/27/22 at 03:13PM Administrative Nurse E stated the facility had been educating staff on the importance of ensuring that potential hazardous materials were secured and had installed magnetic locks on the door and cabinets to protect the residents from access to these chemicals. A review of the facility's "Routine Cleaning and Disinfectant" policy revised 04/2020 indicated that all hazardous cleaning solutions be locked while in resident care area and should never be left unattended. A review of the facility's In-service training indicated that the facility has annual hazardous chemical training scheduled in December 2022. The facility failed to store chemical disinfectant in a secure area placing the 13 cognitively impaired independently mobile residents at risk for injury.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the	F 744		

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appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 49 residents. The sample included 15 residents with two residents reviewed for dementia care (progressive mental disorder characterized by failing memory, confusion). Based on observations, record reviews, and interviews, the facility failed to provide dementia care and services which included adequate supervision and activities to support Resident (R)43 and R49's highest practicable level of well-being. This deficient practice placed the residents at risk for decreased quality of life and impaired well-being due related to dementia.

Findings Included:

- The "Medical Diagnosis" section within R43's Electronic Medical Records (EMR) included diagnoses of dementia, major depressive disorder (major mood disorder), general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), retention of urine (lack of ability to urinate and empty the bladder), benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), left artificial hip.

R43's "Admission Minimum Data Set (MDS)" dated 08/25/22 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe

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cognitive impairment The MDS noted that he required extensive assistance from one staff member for all activities of daily living (ADL's) and utilized a wheelchair for locomotion. The MDS indicated he had hallucinations (sensing things while awake that appear to be real, but the mind created) but no other behaviors.

A review of R43's "Dementia Care Area Assessment (CAA)" dated 08/30/22 indicated that he had advanced cognitive impairment with forgetfulness and hallucinations. The CAA indicated that staff should anticipate his needs and provide reorientation as needed.

R43's "Falls CAA" dated 08/30/22 indicated that he had a history of falls related to his weakness and medical diagnoses. The CAA noted that staff should provide toileting assistance throughout the day and night to prevent unassisted attempts and wandering.

A review of R43's "Care Plan" dated 09/07/22 noted that he had an alteration of thought processes, memory problems, and impaired decision making related to dementia. The care plan noted that he had poor safety awareness and required extensive assistance with dressing, grooming, toileting, bathing, transferring, and locomotion. The care plan noted that staff should provide activities, meal choices, and social interactions to decrease depression, anxiety, or hallucination symptoms. The care plan noted that R43 did wander around the unit exploring the area but was not exit seeking. The plan instructed staff to assist R43 with locating his room and to talk about things of interest to him such as his family or his cats to help reorient him to his environment.

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A review of R43's "Nursing Note" dated 09/17/22 revealed that he attempted to exit the memory care unit by attempting to open the patio doors to go outside. The note indicated that he became agitated when staff moved him into the television room. The note indicated he continued to exhibit exit seeking behaviors the rest of the day and received his ordered medication for anxiety with no improvement. The note lacked documentation showing that non-pharmacological interventions were offered or attempted.

On 09/21/22 at 07:58AM R43 wandered the unit hallway, confused. R43 said he was looking for his wife. He entered R9's (cognitively impaired resident) room, looked around and then exited. He then wandered back up the hall and toward the main entry area to the memory care unit. He entered R49's (cognitively impaired resident) room and sat for five minutes. He then exited the room and went to the dining room area.

On 09/22/22 at 11:11AM R43 led R49 throughout the unit searching for an exit. R43 continued to ask for the exit while going throughout the halls until he entered R29's (cognitively impaired resident) room. R43 watched R29 sleeping in her recliner for five minutes then exited the room. R43 rejoined R49 in the hallway and continued to search for an exit.

On 09/22/22 at 11:58 AM R43 returned back to R29's room. R43 remained in her room until housekeeping staff found him while delivering clean clothing and brought him back out to the main dining area at 12:09PM. R43 had acquired a blue ink pen which he carried while he remained in a state of confusion. At 12:15PM R43 went to

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the rear exit and pushed on the exit door. R43 then came back down the hallway and sat outside his room. R43 punched towards the hallway's handrail twice without making contact to the railing and staff finally met with him.

On 09/26/22 at 02:00PM R43 wandered the memory care unit again leading R49 in search of an exit. At 02:08PM R43 went into R21's (cognitively impaired resident) room and sat watching her as she slept in bed. R43 exited the room after three minutes and returned to wandering with R49.

In an interview on 09/27/22 at 02:30PM with Certified Medication Aid (CMA) R, he stated that R43 did wander around and looked for his wife. He stated that R43 was often easily redirected and participated in activities such as music and exercise groups when engaged by staff. He stated that sometimes the memory care unit got busy with the needs of the residents and often staff were preoccupied with providing care but most of the time the staff was available to supervise the common areas and hallways. He stated that R43 did go into other resident's roomd but should not.

In an interview on 09/27/22 at 02:47PM with Licensed Nurse (LN) G reported that R43 was often confused when he was wandering and often searched for his wife. She stated that staff reoriented him with which room was his and showed him the names and room numbers on the doors to help him understand where he was. She stated that unit activities were provided to keep the residents interested and engaged. She stated that staff provided distractions for wandering residents to help reorient them to the unit such as

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snacks, games, music, or one to one attention. She stated that staff provided frequent restroom breaks and offer daily cares to the residents.

A review of the facility's "Behavioral Health Services" policy revised 09/2022 noted that the facility will provide meaningful activities that encourage engagement with staff, families, and other residents. The policy noted that the necessary and person-centered care will be provided with dignity, autonomy, choice, and safety.

The facility failed to provide dementia care and services to include adequate levels of supervision and activities to support R43's highest practicable level of well-being. This deficient practice placed him at risk for decreased quality of life and impaired well-being due related to dementia.

- The "Medical Diagnosis" section within R49's Electronic Medical Records (EMR) included diagnoses of dementia, generalized anxiety disorder, unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing), osteoarthritis, instability of the right hip.

R49's Quarterly MDS dated 08/22/22 indicated a BIMS score of one indicating severe cognitive impairment. The MDS indicated that she had physical behaviors one to three days a week and verbal behaviors four to six days a week but did not indicate hallucinations (sensing things while awake that appear to be real, but the mind created) or delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The MDS noted no wandering behaviors. The MDS noted she

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required extensive assistance for dressing, transfers, locomotion, toileting, personal hygiene, and bathing from one staff member.

A review of R49's "Dementia CAA" dated 06/06/22 noted that she often yells "help" but cannot articulate what she needs but can make her needs known to staff. The CAA noted for staff to learn her routine and anticipate her needs. R49's "Psychosocial Well-Being CAA" dated 06/06/22 noted she was still adjusting to the neighborhood. The CAA noted she could be anxious and easily agitated. The CAA noted that she usually calmed down with direct staff attention and provided activities.

R49's "Behavioral CAA" dated 06/06/22 noted that that she was anxious much of the time and became combative with attempts to hit staff. The CAA noted that she is easily calmed when staff interact with her or provide one to one attention.

A review of R49's "Care Plan" created 06/13/22 noted the she would become agitated and resistive to care . The plan instructed staff to ensure her safety and give her space to calm down. The plan noted that R49 would see her deceased cousin and yell out for her, become physical aggressive , entering other resident's rooms, and hitting the exit doors. The plan instructed staff to remain calm ensure she has a consistent routine, offer activities and conversations, and give her an item she can fold or fiddle with for entertainment.

On 09/22/22 at 11:11AM R49 was observed in the memory care unit hallway following R43 (severely cognitively impaired resident) down the memory hallway towards room eleven. R49 continued to

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yell out loudly "what am I doing" and "where will I go". R49 continued yelling out for help; no staff responded to her. She then followed R43 up the hallway to the other end of the memory care unit. She continued to ask R43 for help and repeatedly referred to him as "Elsie". No staff were not observed in the hallways or common areas during this timeframe. At 11:46AM R49 remained outside of R29's room as R43 entered the room. R49 yelled out for R43 to get out of the room "Elsie" several times before making her way back down the hall to the dining room. At 11:56AM R49 called out for help and stated "Elsie we need to leave now" several times to R21. At 11:58AM R49 yelled out "I need to go to the bathroom", but staff did not respond. At 12:16PM R49 aggressively grabbed R21's arm and stated, "we need to leave now". Staff intervened and moved R49 to the area on the opposite side of the room. R49 continued to ask for help and then grabbed R24's wheelchair armrest asking R24 to help her get out of here.

On 09/26/22 at 02:08PM R49 followed R43 down the memory care hallway to R21's room. R49 remained outside the room yelling "come out of there Elsie" to R43. R49 returned then wandered the hallways toward the main entry door. R49 continued to call out for help until staff returned to the hallway at 02:45PM.

In an interview on 09/27/22 at 02:30PM with Certified Medication Aid (CMA) R, he stated that R49 often yelled out when wanting attention or someone to talk to. CMA R stated that R49 was easily calmed down if someone sat down and gave her attention. He stated that sometimes the residents wandered the units but residents should never be going into peer's rooms. He stated staff

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needed to ensure the residents had frequent restroom breaks and were assisted with their basic care needs to reduce wandering. He stated that the residents were often provided activities and entertainment to prevent behaviors.

In an interview on 09/27/22 at 02:47PM with Licensed Nurse (LN) G reported that R49 often wandered the unit yelling out for help. She stated that R49 called out the name "Elsie" when she became anxious or agitated. LN G stated that staff often sat with her and gave her direct attention. She stated that R49 was easily redirected when agitated and she often seeked company when wandering the unit. She stated that R49 liked country-gospel music, snacks, and one to one interaction with staff rather then being around groups of people.

A review of the facility's "Behavioral Health Services" policy revised 09/2022 noted that the facility will provide meaningful activities that encourage engagement with staff, families, and other residents. The policy noted that the necessary and person-centered care will be provided with dignity, autonomy, choice, and safety.

The facility failed to provide dementia care and services which included adequate supervision and activities to support R49's highest practicable level of well-being. This deficient practice placed her at risk for decreased quality of life and impaired well-being due related to dementia.