STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089036	A. BUILDING: _____ B. WING _____	C 04/04/2024

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ROLLING HILLS ASSISTED LIVING APARTMENTS	2410 SW URISH ROAD TOPEKA, KS 66614

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #186875, #186846, 187036 and #186685 at the above named facility conducted on 04/03/24 and 04/04/24.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 27 residents with two residents included in the sample and one closed record review. Based on observation, interview, and record review the operator failed to protect one resident from neglect by the failure to ensure facility staff followed the facility's fall protocol policy when Resident (R) 1 fell and refused to get up on 03/28/24. He continued to lay on the floor for at least 10.25 hours until the next morning when he was found by his visiting nurse. R1 was not checked on during the night by facility staff every two hours for bladder incontinence as instructed by his "Negotiated	S3026		

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

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Service Agreement" (NSA). He was not ensured comfort and was not provided a blanket and pillow as instructed. This placed the resident in Immediate Jeopardy.

Findings included:

- Record review for R1 revealed an admission date of 10/31/23 with the following diagnoses: bipolar disorder, anxiety, and depression.

The 01/16/24 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with toileting, was frequently incontinent of bladder, and was marked for falls and inappropriate behavior.

The 01/16/24 "NSA" identified facility staff would provide R1 physical assistance of one staff with toileting; check, change incontinence brief, and provide peri-care every two hours for incontinence of bladder; maintain a safe environment and anticipate needs for falls; and extra staff may be required to manage behaviors. The "NSA" failed to describe specific services staff provided to prevent injury from falls and services staff provided to manage R1's behaviors.

The 04/03/24 "Mini Mental Questionnaire" documented a score of seven, which indicated moderate intellectual function.

Review of nursing progress notes from 01/09/24 to 03/29/24 revealed R1 fell three times in January on 01/09/24, 01/17/24, and 01/23/24; and he fell eight times in March on 03/06/24, 03/18/24, 03/25/24, 03/28/24 and four times in

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S3026	Continued From page 2 one day on 03/29/24. The 03/29/24 "Intake Information" submitted to the State Agency reported Visiting Administrative Nurse F found R1 lying face down on the floor "soaked in urine." R1 had redness on his hip, knees, and ribs. R1 stated he was on the floor all night. Emergency services were contacted to transport R1 to the hospital. R1's record lacked evidence of documentation he fell the evening of 03/28/24 and refused to get up. The record lacked evidence staff conducted vital sign checks, a pain assessment, or nursing assessment for mobility and range of motion after the fall. The record lacked documentation noting staff supplied the resident a pillow and blanket; documentation staff checked R1 every two hours and/or documentation that his incontinence brief was checked/changed, and peri care was provided according to his "NSA." The record failed to show the resident's legal representative or physician were notified, or if the director was notified of the fall. The 03/29/24 notarized "Witness Statement" by Certified Nurse Aide (CNA) G reported R1 was asleep on his bed on 03/28/24 at 07:55 PM. She checked on R1 at 09:40 PM and found him lying on his right side on the floor. CNA G notified the Certified Medication Aide (CMA) on duty and asked for assistance. CNA G asked R1 to use a grab bar beside his bed to help pull himself up while she and the CMA attempted to assist R1 off the floor. R1 refused, rolled onto his stomach, and stated he wanted to be left alone and wanted to sleep on the floor. The CMA on duty notified the nurse.	S3026		

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S3026	Continued From page 3 The 03/29/24 notarized "Witness Statement" by CMA C reported R1 was found on his side on the floor when facility staff went to check on him. They tried for 30 minutes to encourage and assist him off the floor, but he repeatedly refused. CMA C notified Administrative Nurse E of what happened. CMA C was instructed to allow R1 to stay on the floor and ensure he had a blanket and pillow. She passed on the instructions to the CNA on duty and gave report to night shift when they arrived. She worked again on 03/29/24 and showed Visiting Administrative Nurse F to R1's room when she arrived to check on him. R1 continued to lay on his stomach and had urine on his pants. Visiting Administrative Nurse F asked R1 how long he had been lying on the floor. R1 stated he had been on the floor all night. The 03/29/24 notarized "Witness Statement" by CMA D reported she worked night shift on 03/28/24. She was informed by evening shift staff during report R1 had fallen and refused to get off the floor. They were instructed to let him stay on the floor and check on him. She checked R1 around 05:30 AM on 03/29/24 and saw he slept on his side, watched his chest rise and fall, and left. The 04/01/24 facility's "Investigation" submitted to the State Agency on 04/04/24 reported Administrative Staff A reviewed the facility's video footage which revealed the following: On 03/28/24 at 09:40 PM CNA G entered R1's room and found him on the floor. CMA C entered the room shortly after. CNA G and CMA C	S3026		

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remained with R1 and attempted to assist him off the floor.

At 10:00 PM CMA C left R1's room while talking on the phone.

From 10:00 PM to 11:00 PM CNA G and CMA C completed other tasks around the building until night shift arrived at 11:00 PM. Neither of them re-entered R1's room.

From 11:00 PM - 07:00 AM on 03/29/24 CMA D and CNA H worked the night shift. Neither of them entered R1's room until 05:50 AM when CMA D walked into his room for a few seconds, left, and continued to pass medications to the other residents.

03/29/24 at 06:43 AM Administrative Nurse E entered R1's room and exited a few seconds later.

On 04/04/24 Administrative Staff A confirmed by email the dates of some of the falls were incorrect in R1's record. R1 fell on 03/28/24 and was found on the floor by his visiting nurse on 03/29/24. He had a fall in the evening on 03/26/24 and had four falls on 03/27/24. Observation on 04/03/24 at 04:08 of room 202 in the facility revealed the floor was carpeted. A floor-to-ceiling grab bar was near the bed.

On 04/03/24 at approximately 12:53 PM Administrative Staff A stated R1 was transferred to the hospital in the morning on 03/29/24 for evaluation due to weakness and repeated falls. Facility staff did not notify her the evening before (03/28/24) R1 had fallen and refused to get up.

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S3026	Continued From page 5 On 04/03/24 at 03:11 PM Administrative Staff A confirmed evening shift did not check R1 after notifying Administrative Nurse E resident fell and refused to get up. She also confirmed night shift staff did not check R1 until 05:50 AM. On 04/03/24 at approximately 04:00 PM CMA D stated she worked the night shift of 03/28/24 to 03/29/24. It was reported to her during shift report that R1 had fallen and refused to get up. Administrative Nurse E had been notified and instructed staff to leave R1 on the floor. She was not aware if R1 had his call pendant nearby because he usually refused to wear it. CMA D checked on R1 for the first time during the night around 05:30 AM. He laid on his right side facing the door and did not have a blanket or pillow. CMA D confirmed she did not check R1 every two hours according to his "NSA." On 04/04/23 at approximately 09:51 AM CMA C stated she and CNA G found R1 on the floor the evening of 03/28/24. CNA G tried to coax R1 to get off the floor, but he refused. CMA C called Administrative Nurse E. Administrative Nurse E told her to provide a blanket and pillow, ensure he was comfortable, and to check on him. CMA C instructed CNA G to give R1 a blanket and pillow. When night shift arrived, she gave report and included Administrative Nurse E had instructed staff to provide R1 a blanket and pillow and check on him. CMA C stated R1 did not have a call pendant but had a call box on the table next to his bed. On 04/04/23 at approximately 09:51 AM Administrative Staff A stated R1 had been	S3026		

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provided many call pendants because he always lost them. She added he would not be able to reach the call box on the table next to his bed if he was laying on the floor.

The facility's undated "Section 5: Guidelines for the Caregivers at the time of a Fall" policy documented the following:

1. Stay calm and reassure the resident, have the resident stay on the floor.
2. Have another staff member notify the Resident Care Coordinator (RCC) or nurse on call. The RCC will notify the director later when the facts are known.
3. Look for obvious injuries for example: bruising, bleeding, swelling, broken skin, deformed arms or legs that appear out of normal alignment.
4. Ask the resident about pain and where the pain is located.
5. Take vital signs.
6. May place a small pillow under the resident's head for comfort if there is not pain or injury to the head or neck. If the resident hit or may have hit their head, do not lift the neck, or move the head.
7. The RCC or designee will observe the resident's mobility and range of motion.
8. If by all indications the resident does not appear to be injured, two staff members may assist the resident to get up by first sitting up. After putting on a gait belt, assist the resident to their hands and knees. If able and by helping the resident to pull themselves onto a chair or the side of the bed and then to a standing position. If the resident is unable to get up in this fashion, ask him or her what would make it easier to get

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S3026	Continued From page 7 up. 9. Document notes on the event of the fall in Risk Watch if you have reporter status or on paper to be entered later. Always notify the nurse of a fall even if the resident appears not to be injured. 10. The RCC will notify the director and family or Durable Power of Attorney (DPOA) and the physician unless you are directed to do so yourself. 11. The RCC may ask you for a statement or to describe the circumstances of the fall. 12. A Risk Watch occurrence will always be entered. 13. If the resident appears injured 911 will be called by another staff person while you stay with the resident until the emergency team arrives or you are dismissed by the RCC or CMA to return to your duties. The operator failed to protect one resident from neglect by the failure to ensure facility staff followed the facility's fall protocol policy when R1 fell and refused to get up on 03/28/24. He continued to lay on the floor for at least 10.25 hours until the next morning when he was found by his visiting nurse. R1 was not checked through the night by facility staff every two hours for bladder incontinence according to his "NSA." He was not ensured comfort and was not provided a blanket and pillow as instructed. The Immediate Jeopardy was removed on 04/04/24 when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department at 12:43 PM. 1. On 04/01/24 staff were re-educated on	S3026		

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S3026	Continued From page 8 Abuse, Neglect, and Exploitation and Resident Rights. 2. On 04/01/24 staff were re-educated on facility's fall protocol policy. 3. On 04/01/24 staff were re-educated on the list of who to contact when a resident falls. 4. On 04/01/24 staff were re-education on two-hour checks and toileting schedules as the "NSA" and "Healthcare Service Plan" (HSP) indicated for R1. 5. If a resident refused to allow staff to assist them off the floor after a nurse assessed the residents, staff would call emergency services to notify of fall and refusal to get off the floor. Staff would utilize a fall mat, ensure the resident had a pillow and blanket, and ensure the resident was comfortable. Staff would provide 30-minute checks of the resident and offer to assist them off the floor. 6. If a resident refused toileting and/or two-hour checks the nurse would be notified. 7. The Executive Director and RCC or nurse will monitor the above plan during monthly quality assurance meetings.	S3026		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d)	S3082		

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S3082	Continued From page 9 The facility reported a census of 27 residents with two residents included in the sample and one closed record review. Based on interview, and record review the operator failed to ensure designated facility staff ensured the "Functional Capacity Screen" (FCS) for Resident (R) 3 accurately reflected his functional capacity for falls. Findings included: - Record review for R3 revealed an admission date of 01/04/24 with a diagnosis of dementia. The 03/07/24 "FCS" failed to identify R3 was at risk for falls. The 01/04/24 "NSA" failed to identify services R3 received to prevent injury from falls. The 04/04/24 "Resident Roster" provided by the facility documented R3 had at least one fall during the last 180 days. Review of nursing progress notes from admission to time of the survey (90 days) revealed R3 had fallen five times. On 04/04/24 at approximately 11:42 AM Administrative Nurse B confirmed R3's "FCS" failed to identify he was at risk for falls which was not accurate. The operator failed to ensure designated facility staff ensured the "FCS" for R3 accurately reflected his functional capacity for falls.	S3082		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement	S3085		

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S3085	Continued From page 10 (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) The facility reported a census of 27 residents with two residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 1, R2, and R3 described the services they received based on their "Functional Capacity Screens" (FCS) and service needs. Findings included: - Record review for R1 revealed an admission date of 10/31/23 with diagnoses of bipolar	S3085		

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disorder, anxiety, and depression.

The 10/16/24 "FCS" identified R1 was marked for falls and inappropriate behavior.

The 01/16/24 "NSA" identified facility staff would provide R1 a safe environment and anticipate his needs to prevent injury from falls and extra staff may be required to manage behaviors. The "NSA" failed to describe services R1 received for falls and inappropriate behavior based on his specific service needs.

The 03/18/24 "Behavior Note" documented on 03/16/24 R1 verbalized inappropriate language toward facility staff multiple times, and he could do the f___ he wanted. He tried to exit out the secured front door of the building several times. On 03/17/24 R1 verbalized inappropriate language around staff and other residents. Staff requested him to stop because it was upsetting other residents. At approximately 12:30 PM R1 pressed on the front door to exit which activated the alarm several times. 30 minutes later R1 pushed on the fire egress door on 200 hall for 15 seconds which opened the door. He went out of the building for less than five minutes while staff were aware and supervised him. R1 was transferred to the hospital for psychological evaluation and returned later with a report from the hospital he did not meet criteria for a psychological evaluation.

The 03/21/24 "Nurses Note" documented a meeting took place to discuss R1's recent falls and behaviors. Increased anxiety and agitation typically resulted in R1 displaying behavior towards staff and other residents. R1's provider

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was contacted and a new order for lorazepam 0.5 mg every four hours as needed was received.

The 03/28/24 "Behavior Note" documented R1 requested Tylenol. Staff reminded R1 he was not due for pain medication. R1 responded by "muttering" expletives toward the caregiver multiple times. Staff administered R1 lorazepam for his behaviors.

- Record review for R2 revealed an admission date of 03/27/23 with a diagnosis of Alzheimer's Disease.

The 01/16/24 "FCS" identified R2 was sometimes understandable and sometimes understood others during communication and she was marked for falls.

The 01/16/24 "NSA" identified facility staff would maintain a safe environment for falls. The "NSA" failed to describe services R2 received for communication and to prevent injury from falls.

- Record review for R3 revealed an admission date of 01/04/24 with a diagnosis of dementia.

The 03/07/24 "FCS" failed to identify R3 was at risk for falls.

The 01/04/24 "NSA" failed to identify services R3 received to prevent injury from falls.

The 04/04/24 "Resident Roster" provided by the facility documented R3 had at least one fall during the last 180 days.

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S3085	Continued From page 13 Review of nursing progress notes from admission to time of the survey (90 days) revealed R3 had fallen five times. On 04/04/24 at approximately 11:42 AM Administrative Staff A confirmed R1, R2, and R3's "NSA's" failed to describe the services provided based on their "FCS's" and service needs. The operator failed to ensure the "NSA's" for R1, R2, and R3 described the services they received based on their "FCS" and service needs.	S3085		
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 26-41-105(f)(11) The facility reported a census of 27 residents with two residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure licensed staff documented time of occurrence, action taken, and results of the action when Resident (R) 1 fell and refused to get up on 03/28/24. Findings included:	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089036	A. BUILDING: _____ B. WING _____	C 04/04/2024

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S3261	Continued From page 14 - Record review for R1 revealed an admission date of 10/31/23 with the following diagnoses: bipolar disorder, anxiety, and depression. The 01/16/24 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with toileting, was frequently incontinent of bladder, and was marked for falls and inappropriate behavior. The 01/16/24 "NSA" identified facility staff would provide R1 physical assistance of one staff with toileting; check, change incontinence brief, and provide peri-care every two hours for incontinence of bladder; maintain a safe environment and anticipate needs for falls; and extra staff may be required to manage behaviors. The "NSA" failed to describe specific services staff provided to prevent injury from falls and services staff provided to manage R1's behaviors. Review of nursing progress notes from 01/09/24 to 03/29/24 revealed R1 fell three times in January on 01/09/24, 01/17/24, and 01/23/24; and he fell eight times in March on 03/06/24, 03/18/24, 03/25/24, 03/28/24 and four times in one day on 03/29/24. The 03/29/24 "Intake Information" submitted to the department reported Visiting Administrative Nurse F found R1 lying face down on the floor "soaked in urine." R1 had redness on his hip, knees, and ribs. R1 stated he was on the floor all night. Emergency services were contacted to transport R1 to the hospital.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3261	Continued From page 15 R1's record lacked evidence of documentation he fell in the evening on 03/28/24 including the time, action taken, and results of the action. The operator failed to ensure licensed staff documented time of occurrence, action taken, and results of the action when R1 fell and refused to get up on 03/28/24.	S3261		