STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N011007	A. BUILDING: _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AUTUMN PLACE	311 SOUTH EAST AVENUE COLUMBUS, KS 66725

(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 the licensure resurvey with attached complaint numbers 190238 and 190131 for the above named facility conducted on 08/27/24 and 08/28/24.	S 000		
S3028 SS=D	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.	S3028		

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

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (3) The facility reported a census of 13 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on interview and record review the Operator failed to report to the department within 24 hours an allegation of abuse which was alleged to involve R1 and "Certified Medication Aide" (CMA) C. Findings included: - Record review for R1 revealed an admission date of 03/22/21 with diagnoses of Alzheimer's disease, hypothyroidism, hypertension, depression, and edema of the lower extremities. Review of R1's "Functional Capacity Screen" (FCS) dated 04/05/24 revealed R1 was unable to perform bathing, dressing, and toileting. R1 required supervision with walking/mobility. R1 was incontinent, and had impaired short-term memory, impaired long term-memory, impaired memory recall and impaired decision making. She lacked the ability to manage her own medications and medical treatments and she was able to make herself understood and she usually understood others. R1 was identified as a fall risk and used a walker and wheelchair mobility device. Review of R1's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 04/05/24 identified and instructed the facility staff would provide total assistance with bathing, dressing, toileting, and would manage her medications and medical treatments. Facility	S3028		

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S3028	Continued From page 2	S3028		

staff would provide supervision for R1 when transferring and mobility.

Review of R1's "Nurse Notes" dated 02/24/24 to 08/26/24 revealed the following entries:

On 03/06/24 at 10:30 AM revealed R1 had been "very confused" and stated, "she wanted to find a way out of here".

On 03/21/24 at 06:00 AM revealed R1 was found on her bathroom floor.

On 04/25/24 at 06:15 AM revealed R1 was found sitting on the floor in her room.

On 05/06 at 10:00 PM (the year was documented as 2022, the note entered below was dated 05/27/24) revealed the CMA reported to the nurse R1 was anxious and exit seeking.

On 05/07/24 at 01:00 PM revealed R1 was anxious with some confusion.

On 05/11/24 at 02:30 PM R1 was found on the floor in the facility dining room.

On 05/30/24 at 02:00 PM revealed R1 continued to have symptoms of "Sundowners" in the afternoons and the symptoms had been reported to R1's provider and "Durable Power of Attorney" (DPOA).

On 08/05/24 (no time entered) revealed R1 continued to have periods of "Sundowners" with exit seeking behaviors.

On 08/16/24 at 03:30 PM revealed CMA D called the nurse to report that R1 had been up all-night hallucinating.

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S3028	Continued From page 3 On 08/18/24 at 04:30 AM revealed CMA D called the nurse to report R1 had been up all night going into other residents' rooms and banging into walls and door facings. The facility CMA was unsuccessful with redirection. R1's "Nurse Notes" lacked an entry for bruising on R1's wrist and arm. Interview on 08/27/24 at approximately 07:00 PM with "Certified Nurse Aide" (CNA D) confirmed she did call "Licensed Nurse" (LN) B on 08/17/24 after hearing about an incident where CMA C allegedly grabbed R1 aggressively. Interview on 08/28/24 at approximately 03:50 PM with LN B and Operator A confirmed they had been on the phone with each other at the time CNA D called LN B to report the alleged abuse to R1 by CMA C, after CNA D heard about the alleged abuse from staff in the building at the time of the incident. LN B confirmed she reported the allegation from CNA D to Operator A when they resumed their phone conversation. Operator A stated CMA C was passing resident medications that day in the detached assisted living and memory care buildings. She continued to state that she immediately called CMA C, who was named as the alleged perpetrator to leave the assisted living building and go back to the memory care building due to receiving an allegation of abuse. Operator A confirmed she did not report the allegation of abuse to the department within 24 hours. Review of the complaint received by the department revealed that on an unidentified date CMA C was observed to have been "grabbing" R1 "aggressively". It was reported in the complaint	S3028		

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S3028	Continued From page 4 that R1 had bruising on her "Hand" and on "the other arm". The complaint lacked a day of the alleged event. The Operator failed to report to the department within 24 hours an allegation of abuse which was alleged to involve R1 and CMA C.	S3028		
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: K.A.R. 26-41-105 (f) (11) The facility reported a census of 13 residents. The sample included 3 "Residents'" (R)'s 1, 2, and 3. Based on observation, interview, and record review the Operator failed to ensure the resident 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 taken when R1 developed unexplained bruising to the upper left arm and right wrist. Findings included: - Record review for R1 revealed an admission	S3261		

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S3261	Continued From page 5	S3261		

date of 03/22/21 with diagnoses of Alzheimer's disease, hypothyroidism, hypertension, depression, and edema of the lower extremities.

Review of R1's "Functional Capacity Screen" (FCS) dated 04/05/24 revealed R1 was unable to perform bathing, dressing, and toileting. R1 required supervision with walking/mobility. R1 was incontinent, and had impaired short-term memory, impaired long term-memory, impaired memory recall and impaired decision making. She lacked the ability to manage her own medications and medical treatments and she was able to make herself understood and she usually understood others. R1 was identified as a fall risk and used a walker and wheelchair mobility device.

Review of R1's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 04/05/24 identified and instructed the facility staff would provide total assistance with bathing, dressing, toileting, and would manage her medications and medical treatments. Facility staff would provide supervision for R1 when transferring and mobility.

Observation on 08/28/24 at approximately 09:50 AM of R1's arms revealed 2 bruises on the upper left arm oblong in shape approximately an inch in diameter with yellowing edges. There was a bruise on the right wrist approximately 0.5 inches in diameter with yellowing edges.

Interview with R1 on 08/28/24 at approximately 09:50 AM, R1 stated that "no one hurt her."

Review of R1's "Nurse Notes" dated 02/24/24 to 08/26/24 revealed the following entries:

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S3261	Continued From page 6	S3261		

On 03/06/24 at 10:30 AM revealed R1 had been "very confused" and stated, "she wanted to find a way out of here".

On 03/21/24 at 06:00 AM revealed R1 was found on her bathroom floor.

On 04/25/24 at 06:15 AM revealed R1 was found sitting on the floor in her room.

On 05/06 at 10:00 PM (the year was documented as 2022, the note entered below was dated 05/27/24) revealed the CMA reported to the nurse R1 was anxious and exit seeking.

On 05/07/24 at 01:00 PM revealed R1 was anxious with some confusion.

On 05/11/24 at 02:30 PM R1 was found on the floor in the facility dining room.

On 05/30/24 at 02:00 PM revealed R1 continued to have symptoms of "Sundowners" in the afternoons and the symptoms had been reported to R1's provider and "Durable Power of Attorney" (DPOA).

On 08/05/24 (no time entered) revealed R1 continued to have periods of "Sundowners" with exit seeking behaviors.

On 08/16/24 at 03:30 PM revealed CMA D called the nurse to report that R1 had been up all-night hallucinating.

On 08/18/24 at 04:30 AM revealed CMA D called the nurse to report R1 had been up all night going into other residents' rooms and banging into walls and door facings. The facility CMA was unsuccessful with redirection.

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S3261	Continued From page 7 R1's "Nurse Notes" lacked an entry for bruising on R1's wrist and arm. Interview on 08/28/24 at approximately 03:50 PM with LN B and Operator A confirmed R1's record lacked documentation of the bruising to the left upper arm and to the right wrist. The Operator failed to ensure the resident 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 taken when R1 developed unexplained bruising to the upper left arm and right wrist.	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.	S3280		

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S3280	Continued From page 8 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 13 residents. Based on interview and record review the operator failed to ensure documentation of the emergency preparedness training at least quarterly for all residents. Findings included: - Interview on 08/27/24 at approximately 10:20 AM with Operator A confirmed the quarterly emergency preparedness training for all residents is presented at the time of the resident council meetings. Record review of the only resident council meeting notes for 2024, revealed there was a resident signature page for 04/02/24. The topics listed on the bottom of the page were the following: Scrambled eggs Hand sanitizer on all tables Weights and Vitals July 4th events The record lacked the topic of emergency preparedness. Interview on 08/27/24 at approximately 10:20 AM with Operator A confirmed the resident council meeting book lacked documentation of the emergency preparedness training at least quarterly. The operator failed to ensure documentation of the emergency preparedness training at least	S3280		

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S3280	Continued From page 9 quarterly for all residents.	S3280		