

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2024
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175474 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/17/2024 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CHAPMAN VALLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1009 N MARSHALL CHAPMAN, KS 67431 | | |
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| F 000 | INITIAL COMMENTS | F 000 | | | |
| F 689 SS=G | <p>The following citations are the result of abbreviated survey and complaint investigation KS00185063, KS00184799, and KS00183046.</p> <p>The 2567 was sent electronically on 01/30/24.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 identified a census of 28 residents with three residents reviewed for falls and accidents. Based on record review, observation, and interview, the facility failed to follow Resident (R) 1's fall interventions, which resulted in a fall from R1's bed and R1 sustained a broken nasal bone. On 01/07/23 at 04:15 PM, staff provided care to R1 but did not replace the fall mat next to R1's bed when they left the room. Certified Medication Aide (CMA) M later found R1 lying on the floor on her stomach with her face in a pool of blood and blood running out of her nose. R1 was transferred to the emergency room where she was diagnosed with a broken nasal bone. This deficient practice also placed R1 at risk for injury, pain, and bruising.</p> <p>Findings included:</p> | F 689 | Past noncompliance: no plan of correction required. | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

01/30/2024

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 - R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) with behavioral disturbance, cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and seizures (violent involuntary series of contractions of a group of muscles). The "Quarterly Minimum Data Set (MDS)," dated 10/09/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R1 required substantial/maximum assistance from staff for eating, oral hygiene, upper body dressing, personal hygiene, and bed mobility. The MDS documented R1 was dependent on staff for lower body dressing, putting on and taking off shoes, transfer, bathing, and locomotion in a wheelchair. The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 01/07/24, documented R1 had late-stage dementia, was unable to follow simple commands, and often answered questions inappropriately. The CAA documented R1 could not focus, a history of restlessness, and a history of lethargy. The "Falls CAA," dated 01/07/24, documented R1 had to be transferred with a full body lift and had a suspected stroke with right-sided flaccidity. The CAA documented fall interventions including decreasing R1's time in bed, a slightly built-up mattress, and a memory foam fall mattress. | F 689 | | | |

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| F 689 | <p>Continued From page 2</p> <p>R1's "Care Plan" initiated on 01/19/22 and revised on 01/08/24 documented R1 had an unwitnessed roll out of bed with a major injury dated 11/04/23. The care plan directed staff to get R1 up when she was awake (11/06/23), place a fall mat at her bed side (01/08/24), ensure bed was in lowest position (01/19/23), and ensure a sensor alarm was in place when R1 occupied her bed (01/08/24). The care plan directed staff to transfer R1 with two staff assist and a full body lift (12/29/23) and R1 was dependent on staff for locomotion in her wheelchair (10/11/23).</p> <p>R1's "Fall Risk Assessment," dated 11/04/23, documented R1 was a high fall risk.</p> <p>The "Incident Note," dated 01/07/24, documented CMA M reported R1 was lying face down on the floor by her bed. R1's bed was in the lowest position. Licensed Nurse (LN) G documented she and CMA M were in R1's room a few minutes before the fall attempting to help R1 keep her shirt on. LN G let R1 know a Certified Nurse's Aide (CNA) would be in shortly to get her up for supper. LN G documented she moved the fall mat with the sensor alarm from R1's bedside when she was putting R1's shirt back on and did not put it back because the CNA was going to be getting R1 up for supper soon. LN G placed a U-shaped pillow around R1 and gave her the call light. LN G documented after R1 fell, R1's nose was swollen and purple with a small cut on the bridge of R1's nose and a moderate amount of blood coming from both nostrils. LN G applied pressure to stop the bleeding. R1 had a 5 centimeter (cm) hematoma to the left side of her head and a 3.5 cm hematoma (abnormal pooling of blood in the body under the skin that results from a broken or ruptured blood vessel) to her left</p> | F 689 | | | |

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| F 689 | <p>Continued From page 3</p> <p>forehead. R1 was alert and oriented to herself only and had equal hand grips. R1 answered questions appropriately for her. Emergency Medical Staff (EMS) arrived and transferred R1 to the emergency room.</p> <p>The "Incident Note," dated 01/07/24, documented LN G received a phone call from the emergency room nurse with a report regarding R1. R1 had extensive bruising to her face and had a right nasal bone fracture. R1 received a dose of blood pressure medication in the emergency room due to elevated blood pressure.</p> <p>The "Incident Note," dated 01/07/24, documented R1 returned to the facility at 08:05 PM. R1 had dark purple discoloration on her left forehead, mouth, under her right eye, and across the bridge of her nose.</p> <p>The "Incident Note," dated 01/08/24, documented R1 had extensive bruising to her face and swelling to her nose due to a nasal fracture. The fall mats and sensor alarms remained in place while R1 was in bed.</p> <p>The "Facility Incident Report," dated 01/08/24, documented staff assisted R1 in putting her shirt back on correctly then placed a U-shaped pillow in the bed with R1 and covered R1. Staff left R1's room to assist another resident. R1's fall mat was moved by LN G and LN G did not put the fall mat back by the side of the bed. When staff went back to R1's room, R1 was face down on the floor. R1 had a bloody nose and a bump at the top of her nose that started to bruise and swell. The investigation recorded the corrective actions included the U-shaped pillow was removed from R1's room, staff continued R1's bed in the low</p> | F 689 | | | |

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| F 689 | <p>Continued From page 4</p> <p>position, and staff received education on replacing the fall mat before leaving the room and following R1's plan of care. Staff were to ensure the sensor pad was on R1's bed, and R1's fall mat was changed to a memory foam topper.</p> <p>On 01/17/24 at 10:00 AM, observation revealed R1 sat in her wheelchair in the dining room with her eyes closed. R1 continued to have extensive bruising under her eyes, across her nose, and up into her forehead. R1 did not respond to verbal stimuli.</p> <p>On 01/17/24 at 10:10 AM, observation revealed a memory foam fall mat on top of R1's bed.</p> <p>On 01/17/24 at 10:15 AM, CMA N stated R1's fall interventions in place before the last fall was for staff to ensure the sensor alarm was in her bed and ensure R1 had a fall mat at her bedside. CMA N stated the sensor alarm was to follow R1 wherever she went.</p> <p>On 01/17/24 at 10:30 AM, Administrative Nurse D stated she expected all of her staff to follow R1's care plan and ensure the fall mat was in place before leaving R1's room.</p> <p>The facility's "Fall Prevention Policy," dated 01/06/23, documented each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. Primary interventions included: a low bed, fall mats, clear pathways, assistive devices, and monitoring for changes in the resident's cognition, gait, ability to rise/sit, and balance.</p> <p>The facility failed to ensure a safe environment</p> | F 689 | | | |

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| F 689 | Continued From page 5 for R1 when staff failed to place her fall mat at the bedside as directed by R1's care plan. This deficient practice resulted in a facial fracture due to a fall from the bed and placed R1 at risk for pain. On 01/10/24, the facility identified and completed all corrective actions including staff education on following residents' plan of care and fall prevention interventions. All actions were completed before the onsite survey therefore the deficient practice was deemed past noncompliance and remained at a "G" scope and severity. | F 689 | | | |
| F 760 SS=D | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents with three residents reviewed for medication errors. The facility failed to prevent a significant medication error when staff administered amlodipine (medication used to treat high blood pressure) instead of amiodarone (medication used to regulate heart rate) to Resident (R) 2. This deficient practice placed R2 at risk for health complications and medication-related adverse effects. Findings included: - R2's Electronic Medical Record (EMR) documented R2 had diagnoses of atrial fibrillation (fast, irregular heartbeat), hypertension (high | F 760 | | | |

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| F 760 | <p>Continued From page 6 blood pressure), and chronic pain.</p> <p>The "Admission Minimum Data Set (MDS)," dated 10/27/23, documented R2 had a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. The MDS documented R2 required substantial/maximum staff assistance for bed mobility, transfer, and ambulation. R2 required partial/moderate staff assistance for eating, toileting hygiene, upper body dressing, and personal hygiene.</p> <p>The "Cognitive Loss/Dementia Care Area Assessment," dated 10/27/23, documented R2 was forgetful, and her husband helped her at home to remember things and keep track of the days. R2 had depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) due to chronic pain.</p> <p>R2's "Care Plan directed staff to administer R2's medications as ordered and to monitor R2 for any adverse side effects.</p> <p>The Electronic Medication Administration Record (EMAR) dated 10/21/23, documented R1 was prescribed amiodarone 200 mg by mouth daily.</p> <p>The "Health Status Note," dated 11/17/23, documented R2's primary care physician discontinued R2's amlodipine 10 milligrams (mg) daily.</p> <p>The "Facility Incident Report," dated 11/27/23, documented R2 received the wrong medication, (amlodipine). R2 received amlodipine 10 mg from 11/18/23 through 11/24/23 due to the medication</p> | F 760 | | | |

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| F 760 | <p>Continued From page 7</p> <p>card not being removed from the medication cart. Staff administered amlodipine incorrectly instead of amiodarone. The investigation documented corrective action for the situation was a system in which the nurse who received the order to discontinue a medication would pull the discontinued medication immediately.</p> <p>The "Facility Facsimile," dated 11/27/23, documented Administrative Nurse D notified R2's primary care physician R2 received amlodipine 10 mg daily from 11/18/23 through 11/24/23 after being discontinued and did not receive amiodarone 200 mg daily during the same time. Administrative Nurse D faxed R2's blood pressure and pulses and reported R2 continued to have swelling.</p> <p>On 01/17/24 at 10:00 AM, observation revealed R2 sat at a table with friends talking and drinking coffee.</p> <p>On 01/17/24 at 10:00 AM, R2 stated that she liked living in the facility and it felt just like home. R2 stated she received good care at the facility.</p> <p>On 01/27/23 at 11:00 AM, Administrative Nurse D stated that she expected staff to follow the "rights" of medication administration and ensure they were administering the correct medications to the residents.</p> <p>The facility's "Medication Administration Policy," dated 01/04/24, documented medications are administered as prescribed, in accordance with good nursing principles and practices, and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the</p> | F 760 | | | |

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| F 760 | Continued From page 8 medications. The facility failed to follow the standards rights of drug administration in checking for the right medication which resulted in a significant medication error for R2. This deficient practice placed R2 at risk for health complications and medication-related adverse effects. | F 760 | | | |