Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046035	A. BUILDING: ______ B. WING ______	C 03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONLEA COTTAGE OF OLATHE	**625 LINCOLN AVE 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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations are the result of a Licensure Resurvey at the above named Residential Health Care Facility in Olathe, Kansas on 3/10/15, 3/11/15, 3/12/15, 3/16/15, and 3/17/15. Complaints #84781 and #78824 also investigated.	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.	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: KAR 26-41-101(f)(3) The census equalled 41 the sample included three Residents, and one focused review completed. Based on reviews of records and interviews, for one of three sampled (#185), the Operator failed to thoroughly investigate incidents with injury or complaints of pain, when Resident unable to explain, to rule out potential abuse or neglect. Findings included: - Review of record revealed #185 admitted to facility with diagnoses of Anxiety, Coronary artery disease, Hypertension, Hypothyroidism, Overactive bladder, and Pain. The most recent functional capacity screen (FCS) lacked a date, and assessed #185 in need of supervision with bathing and medication management; with memory and decision making impairments; with history of falls/unsteadiness; and used a walker. The most recent 10/15/14 negotiated service agreement (NSA) documented facility staff to provide the needed services to Resident for medication management and shower set up; the NSA documented history of falls and unsteadiness but lacked any services to address this history. Medical record Progress Notes (PN) documented the following: 11/02/14 - Nurse notified Resident found on floor... laying on back of head with change in mental status... sent to hospital for evaluation and treatment... found with UTI (urinary tract	S3028		

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S3028	Continued From page 2 infection)... The note lacked time of fall/discovery on floor, time of transport to hospital, time of return to facility. The note lacked documentation of an assessment of Resident's symptoms. The record lacked an investigation into causal factors and responses to rule out any abuse or neglect issues. 9/26/13 - Resident found on ground in front of facility, denies pain... 9/26/13 - returned from outing with family... complained of pain to chest area, nickel size bump found to breast area... physician called... STAT X-ray... family notified... 9/27/13 - Continued to complain of discomfort... X-ray results faxed to physician, no new orders... cold pack applied to chest... The notes lacked times, and lacked an assessment of Resident's symptoms of injuries with complaint of pain. The record lacked an investigation into causal factors of fall and of complaint of pain with injury, and responses to complaints, to rule out any abuse or neglect issues. By interview on 3/12/15 at 12:20pm, DON (Director of Nursing) #F stated 11/02/14 "change of status" meant #185 "was shaking and such and really couldn't talk to us"... confirmed no further assessment of Resident or investigation into cause documented. When asked if any other details or documentation of 11/02/14 fall available, DON #F stated we have a fall log. This fall log documented: 11/02/14 - 1:30pm - found on floor unaware of what happened... no complaint of pain no visible injury... to hospital, unable to answer questions... family, physician, DON notified... sent back from	S3028		

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S3028	Continued From page 3 hospital no orders Resident fine... 9/26/13 - 12:00pm - stated was folding walker, fell, hit leg on bench... bruise lower right leg... ROM, vitals This log also failed to indicate an investigation completed into causal factors and corrective actions taken, to rule out any abuse or neglect issues. By interview on 3/12/15 at 12:35pm Operator #D stated no documentation/investigations available. The Operator failed to thoroughly investigate incidents of #185 with injury or complaints of pain Resident unable to explain, to rule out potential abuse or neglect.	S3028		
S3085 SS=F	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.	S3085		

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S3085	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The census equalled 41 the sample included three Residents, and one focused review completed. Based on interviews and reviews of records, for two of three sampled (#189 and #185), and for one of one focused review (#182), the Operator failed to ensure the development of a written negotiated service agreement for each Resident based on the functional capacity screen and service needs, which included a description of the the services the Resident to receive. Findings included: - Review of record revealed #185 admitted to facility with diagnoses of Anxiety, Coronary artery disease, Hypertension, Hypothyroidism, Overactive bladder, and Pain. The most recent functional capacity screen (FCS) lacked a date, and assessed #185 in need of supervision with bathing and medication management; with memory and decision making impairments; with history of falls/unsteadiness; with inappropriate behaviors; and used a walker. The most recent 10/15/14 negotiated service agreement (NSA), documented facility staff to provide the needed services to Resident for medication management and shower set up. The NSA documented "history of falls and unsteadiness" but lacked any services to address this identified need. The NSA documented "will redirect when having behavior issues" but lacked specific interventions	S3085		

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S3085	Continued From page 5	S3085		

or services to address this identified need.

Medical record Progress Notes (PN) documented "falls" on 11/02/14, 4/01/14, 12/27/13, and 9/26/13.

By interview on 3/12/15 at 12:20pm, DON (Director of Nursing) #F confirmed Resident experienced falls... no other information available for falls on the NSA... stated not in record but we have a fall log.

This fall log documented additional incidents not found in the Medical Record PN:
8/07/14 - (no time) - stated tripped over chair... no complaint of pain, no visible injury... ROM (range of motion), vitals, Dr., DON, family notified...
3/01/14 - 4:30pm - fell in bathroom, complained of pain in right side, abrasion to right eye... ROM, vitals, family transported to hospital... sent back...

The Operator failed to ensure the development of a written NSA for #185 based on the functional capacity screen and service needs, which included a description of the the services the Resident to receive in regard to behaviors, falls, and unsteadiness.

- Review of record revealed #182 admitted to facility 7/15/13 with diagnoses of Dementia, Depressive disorder, Hypertension, and Plantar fascitis.
The current 10/03/14 functional capacity screen (FCS) assessed #182 in need of supervision with bathing and medication management; with memory and decision making impairments; with history of falls/unsteadiness; used a walker and a wheelchair.
The current 10/03/14 negotiated service

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S3085	Continued From page 6 agreement (NSA) documented facility staff to provide the needed services to Resident for medication management and shower set up. The NSA documented "history of falls" but lacked any services to address this identified need. Medical record Progress Notes (PN) documented the following: 8/29/14 - Resident found on floor... stated was dizzy and lost balance... complained of pain to hip and back... 911 called 01/15/14 - Resident found on floor... stated was putting on pants and lost balance... 8/06/13 - Resident found on floor in bathroom... states reaching for toilet paper... slid off toilet... The Operator failed to ensure the development of a written NSA for #182 based on the functional capacity screen and service needs, which included a description of the services the Resident to receive in regard to falls and unsteadiness. - Review of record revealed #189 admitted to facility 8/01/12 with diagnoses of Atrial fibrillation, Anxiety, Aphasia, Appendectomy, B12 deficiency, Bells palsy, Constipation, Depression, Cardiovascular accident, Degenerative joint disease, Dysphagia, Encephalopathy, Fall risk, and Gastroesophageal reflux disease. The current 8/27/14 functional capacity screen (FCS) assessed #189 unable to perform medication and treatment management; memory and decision making impairments; with falls and unsteadiness; with inappropriate behaviors; and used a walker. The current 8/27/14 negotiated service agreement (NSA) documented facility staff to	S3085		

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S3085	Continued From page 7 provide the needed services to Resident for medication and treatment management. The NSA documented "staff will provide services for behavior" but failed to identify behaviors and interventions to address these. The NSA lacked any services for falls, unsteadiness. By interview on 3/12/15 at 11:00am, DON (director of nursing) #F stated we don't really have a fall or behavior plan on the NSA... occasionally will start cussing if gets upset... storms off... if in a bad mood will say I need my mood pill... The Operator failed to ensure the development of a written NSA for #189 based on the functional capacity screen and service needs, which included a description of the services the Resident to receive in regard to behaviors, falls, and unsteadiness.	S3085		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The census equalled 41 the sample included three sampled Residents, and one focused review completed. Based on reviews of records and interviews, for one of three sampled (#185) and one focused review (#182), the Operator failed to ensure all health care services, including	S3171		

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S3171	Continued From page 8	S3171		

assessments of Residents, provided by qualified staff in accordance with acceptable standards of practice.

Findings included:

- Review of record revealed #185 admitted to facility with diagnoses of Anxiety, Coronary artery disease, Hypertension, Hypothyroidism, Overactive bladder, and Pain.
The most recent functional capacity screen (FCS) lacked a date, and assessed #185 in need of supervision with bathing and medication management; with memory and decision making impairments; with history of falls/unsteadiness; and used a walker.
The most recent 10/15/14 negotiated service agreement (NSA) documented facility staff to provide the needed services to Resident for medication management and shower set up; the NSA documented history of falls and unsteadiness but lacked any services to address this history.

Medical record Progress Notes (PN) documented the following:
11/02/14 - Nurse notified Resident found on floor... laying on back of head with change in mental status... sent to hospital for evaluation and treatment...
The note lacked documentation of an assessment of Resident's symptoms.

4/01/14 - Resident knee gave out in hallway... non responsive one minute... unable to tell me his/her name, blood pressure down... Dr. notified, sent to hospital... family and 911 called...
4/02/14 - admitted to hospital for fever, syncope, pneumonia... will continue to follow up...
The notes lacked documentation of an

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S3171	Continued From page 9	S3171		

assessment of Resident's symptoms of injuries and illness.

12/27/13 - Resident reported he/she fell 12/25/13 and got self up... family and physician notified... continued to complain of pain left rib... X-ray provided, report faxed to physician... new orders...
The notes lacked documentation of an assessment of Resident's symptoms of injuries with complaints of pain. The notes lacked follow-up actions of the X-rays.

9/26/13 - Resident found on ground in front of facility, denies pain...
The note lacked an assessment of Resident's condition when found on the ground.

9/26/13 - returned from outing with family... complained of pain to chest area, nickel size bump found to breast area... physician called... STAT X-ray... family notified...
9/27/13 - Continued to complain of discomfort... X-ray results faxed to physician, no new orders... cold pack applied to chest...
The notes lacked an assessment of Resident's symptoms of injuries with complaint of pain.

By interview on 3/12/15 at 12:20pm, DON (Director of Nursing) #F stated 11/02/14 "change of status" meant #185 "was shaking and such and really couldn't talk to us"... confirmed no further assessment of Resident documented. When asked if any other details or documentation of 11/02/14 fall available, DON #F stated we have a fall log.

This fall log documented:
11/02/14 - 1:30pm - found on floor unaware of what happened... no complaint of pain no visible

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S3171	Continued From page 10 injury... to hospital, unable to answer questions... family, physician, DON notified... sent back from hospital no orders Resident fine... 8/07/14 - (no time) - stated tripped over chair... no complaint of pain, no visible injury... ROM (range of motion), vitals, Dr., DON, family notified... 3/01/14 - 4:30pm - fell in bathroom, complained of pain in right side, abrasion to right eye... ROM, vitals, family transported to hospital... sent back... 12/25/13 - 9:30am - stated was walking to bed, lost balance, hit corner of night stand... bruise left hip, complained of side pain... X-ray, ROM, vitals... 9/26/13 - 12:00pm - stated was folding walker, fell, hit leg on bench... bruise lower right leg... ROM, vitals 8/19/13 - 5:00pm - stated walked too far and fell to knee... no complaint of pain, no visible injuries... ROM, vitals Medical Record PN lacked any documentation of incidents on 8/07/14 and 3/01/14. Medical Record PN lacked documentation of assessments by a licensed nurse of Residents symptoms and signs of injuries. By interview on 3/12/15 at 12:35pm Operator #D stated no documentation/assessments/investigations available. By interview on 3/12/15 at 1:30pm, Operator #D reviewed policy and procedure manual... confirmed nothing available for criteria of when staff need to call a nurse... nothing for the CMA's role in responding without assessing when falls, incidents, and changes in condition occur. Operator #D provided a CMA job description. Review of this document provided no clarification. The Operator failed to ensure all health care	S3171		

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S3171	Continued From page 11	S3171		

services, including assessments of Residents, provided to #185 by qualified staff in accordance with acceptable standards of practice.

- Review of record revealed #182 admitted to facility 7/15/13 with diagnoses of Dementia, Depressive disorder, Hypertension, and Plantar fascitis.
The current 10/03/14 functional capacity screen (FCS) assessed #182 in need of supervision with bathing and medication management; with memory and decision making impairments; with history of falls/unsteadiness; used a walker and a wheelchair.
The current 10/03/14 negotiated service agreement (NSA) documented facility staff to provide the needed services to Resident for medication management and shower set up; the NSA documented history of falls but lacked any services to address this history.

Medical record Progress Notes (PN) documented the following:
8/29/14 - Resident found on floor... stated was dizzy and lost balance... complained of pain to hip and back... 911 called, family and physician notified...
9/02/14 - Resident will be moving to different facility for rehabilitation post surgery...

The medical record lacked documentation of an assessment completed by a licensed nurse of Resident's condition at the time Resident discovered on the floor with complaints of pain.

On 3/12/15 at 1:00pm Operator #D provided a packet that contained investigation documents... confirmed no other documentation available for medical record.

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S3171	Continued From page 12 On 3/12/15 at 1:06pm, DON (director of nursing) #F stated if here I do an assessment in person... if not here they call me from Resident room on phone before doing anything... I ask them questions even before they are moved... will put them on speaker phone... anything like that is documented in the Nurses' Notes (progress notes). The facility investigation documented CMA (certified medication aide) completed assessment... stated CMA did ROM (range of motion) of Resident #182 at time of fall. The Investigation lacked an assessment completed by a licensed nurse. An Incident Report provided for review also documented by the CMA but lacked indication of Licensed Nurse assessment or participation. By interview on 3/12/15 at 3:15pm, CMA #K stated when someone falls, we call the DON... ask them if they hurt... do the ROM... make sure they can move their arms and legs... usually on cell phone with DON... talk through while in the room... The Operator failed to ensure all health care services, including assessments of Residents, provided to #182 by qualified staff in accordance with acceptable standards of practice.	S3171		
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	S3261		

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S3261	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-41-105 The census equalled 41 the sample included three sampled Residents, and one focused review completed. Based on reviews of records and interviews, for one of three sampled (#185) and one focused review (#182), the Operator failed to ensure 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: - Review of record revealed #185 admitted to facility with diagnoses of Anxiety, Coronary artery disease, Hypertension, Hypothyroidism, Overactive bladder, and Pain. The most recent functional capacity screen (FCS) lacked a date, and assessed #185 in need of supervision with bathing and medication management; with memory and decision making impairments; with history of falls/unsteadiness; and used a walker. The most recent 10/15/14 negotiated service agreement (NSA), documented facility staff to provide the needed services to Resident for medication management and shower set up; the NSA documented history of falls and unsteadiness but lacked any services to address this history. Medical record Progress Notes (PN) documented the following:	S3261		

Kansas Department on Aging

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	N046035	A. BUILDING: ______ B. WING ______	C 03/17/2015

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S3261	Continued From page 14 11/02/14 - Nurse notified Resident found on floor... laying on back of head with change in mental status... sent to hospital for evaluation and treatment... found with UTI (urinary tract infection)... The note lacked time of fall, time of transport to hospital, time of return to facility. The note lacked documentation of an assessment of Resident's symptoms. 4/01/14 - Resident knee gave out in hallway... non responsive one minute... unable to tell me his/her name, blood pressure down... Dr. notified, sent to hospital... family and 911 called... 4/02/14 - admitted to hospital for fever, syncope, pneumonia... will continue to follow up... returned from hospital, no new orders... The notes lacked time of fall, time of transport to hospital, time of return to facility. The notes lacked an assessment of Resident's symptoms of injuries and illness. 12/27/13 - Resident reported he/she fell 12/25/13 and got self up... family and physician notified... continued to complain of pain left rib... X-ray provided, report faxed to physician... new orders... The notes lacked times, and lacked an assessment of Resident's symptoms of injuries with complaints of pain. The notes lacked follow-up actions of the X-rays. 9/26/13 - Resident found on ground in front of facility, denies pain... The note lacked time, lacked an assessment of Resident's condition, lacked actions taken. 9/26/13 - returned from outing with family... complained of pain to chest area, nickel size bump found to breast area... physician called...	S3261		

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S3261	Continued From page 15 STAT X-ray... family notified... 9/27/13 - Continued to complain of discomfort... X-ray results faxed to physician, no new orders... cold pack applied to chest... The notes lacked times, and lacked an assessment of Resident's symptoms of injuries with complaint of pain. By interview on 3/12/15 at 12:20pm, DON (Director of Nursing) #F stated no times on documentation because have just always done it that way... stated 11/02/14 "change of status" meant #185 "was shaking and such and really couldn't talk to us"... confirmed no further assessment of Resident documented. When asked if any other details or documentation of 11/02/14 fall available, DON #F stated not in record but we have a fall log. This fall log documented: 11/02/14 - 1:30pm - found on floor unaware of what happened... no complaint of pain no visible injury... to hospital, unable to answer questions... family, physician, DON notified... sent back from hospital no orders Resident fine... 8/07/14 - (no time) - stated tripped over chair... no complaint of pain, no visible injury... ROM (range of motion), vitals, Dr., DON, family notified... 3/01/14 - 4:30pm - fell in bathroom, complained of pain in right side, abrasion to right eye... ROM, vitals, family transported to hospital... sent back... 12/25/13 - 9:30am - stated was walking to bed, lost balance, hit corner of night stand... bruise left hip, complained of side pain... X-ray, ROM, vitals... 9/26/13 - 12:00pm - stated was folding walker, fell, hit leg on bench... bruise lower right leg... ROM, vitals 8/19/13 - 5:00pm - stated walked too far and fell to knee... no complaint of pain, no visible	S3261		

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S3261	Continued From page 16 injuries... ROM, vitals Medical Record PN lacked any documentation of incidents on 8/07/14 and 3/01/14, to include time, occurrence, actions taken, and results of actions. Medical Record PN lacked documentation of assessments of Residents symptoms and signs of injuries. By interview on 3/12/15 at 12:35pm Operator #D stated no documentation/investigations available. The Operator failed to ensure the medical record of #185 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. - Review of record revealed #182 admitted to facility 7/15/13 with diagnoses of Dementia, Depressive disorder, Hypertension, and Plantar fascitis. The current 10/03/14 functional capacity screen (FCS) assessed #182 in need of supervision with bathing and medication management; with memory and decision making impairments; with history of falls/unsteadiness; used a walker and a wheelchair. The current 10/03/14 negotiated service agreement (NSA) documented facility staff to provide the needed services to Resident for medication management and shower set up; the NSA documented history of falls but lacked any services to address this history. Medical record Progress Notes (PN) documented the following: 8/29/14 - Resident found on floor... stated was dizzy and lost balance... complained of pain to hip	S3261		

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S3261	Continued From page 17 and back... 911 called, family and physician notified... 9/02/14 - Resident will be moving to different facility for rehabilitation post surgery... The medical record lacked documentation of the time of discovery and/or time of fall. The note lacked documentation of an assessment of Resident's symptoms and signs of injuries. The note lacked time of transport to hospital, details of admission to hospital and transfer to another facility, and lacked time of return to facility, or an assessment of Resident's condition upon return to facility. On 3/12/15 at 1:00pm Operator #D provided a packet that contained investigation documents... confirmed no other documentation available for medical record. The Operator failed to ensure the medical record of #182 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.	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;	S3280		

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S3280	Continued From page 18 (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 by: KAR 26-41-104(d) The facility census equalled 41 the sample included three Residents, and one focused review completed. The facility identified 13 employees hired since the last Resurvey. Based on interviews and reviews of records, the Operator: Failed to ensure disaster and emergency preparedness by conducting quarterly reviews of the facility's emergency management plan with employees; and, Failed to ensure an emergency evacuation drill conducted at least annually with staff and Residents. Findings included: - On 3/12/15 at 11:00am, Operator #D provided the last two emergency evacuation dates... 10/28/13 and 12/31/14... Operator #D acknowledged these were completed more than a year apart. On 3/12/15 at 2:55pm, Operator #D stated I do the disaster and emergency review with employees at time of hire and then annually... not aware this was to be quarterly... Operator	S3280		

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S3280	Continued From page 19 provided dates of quarterly reviews completed with Residents. The Operator failed to ensure reviews of the facility's emergency management plan completed with employees quarterly, and failed to ensure emergency evacuation drills conducted at least annually with staff and Residents.	S3280		