STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N063012	A. BUILDING: _____ B. WING _____	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY VILLAGE	3800 ASBURY DRIVE COFFEYVILLE, KS 67337

(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 an abbreviated survey for complaints # 190122 of the above named facility conducted on 09/03/24.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-201 (c) (2) The facility reported a census of 20 residents. The sample included one "Resident" (R). Based on interview and record review the operator failed to ensure a screening was performed determining the functional capacity for R1 when she experienced a change of condition. Findings included: - Record review for R1 revealed an admission date of 04/13/22 with diagnoses of anxiety, dementia, anemia, and hypothyroidism. Review of R1's "Functional Capacity Screen" (FCS) dated 09/20/23 revealed R1 required	S3081		

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

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S3081	Continued From page 1	S3081		

supervision with bathing and dressing. R1 was scored with impaired short-term memory, long-term memory, memory recall, and decision making. She was usually able to make herself understood and she usually understood others. R1 was identified as having impaired hearing and inappropriate behavior.

The FCS did not identify R1 as having wandering behavior.

Review of R1's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 09/20/23 identified facility staff would provide supervision for bathing and prompts for dressing. In the section titled "Mentation" facility staff were instructed to provide prompts and reminders to complete task due to "forgetfulness and confusion." In the section titled "Behavior" it identified R1 as having confusion and forgetfulness being noted at times. Staff were instructed to provide one-on-one for reassurance due to anxiety.

Review of the facility's "Elopement Risk Assessment" revealed R1 had a history of dementia, and she became confused outside the facility. She wandered within the facility but did not "Exit seek", and she lived in the assisted living and was a moderate risk for elopement.

The combined NSA/HSP did not identify health services for wandering behaviors.

Review of R1's "Resident Notes" dated 10/26/23 to 09/03/24 revealed the following entries:

On 01/10/23 (entry not timed) R1's daughter told the facility nurse she spoke to R1's provider about R1 having increased confusion when returning to

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S3081	Continued From page 2	S3081		

the facility after going on an outing. The decision was made to change to a provider that would see the resident in the facility.

On 03/06/24 (entry not timed) The facility nurse reported to the provider R1 was having ear pain, she was having increased behaviors, episodes of crying, becoming frustrated, showing agitation towards staff and she was refusing to eat meals. Order for a urinalysis obtained.

On 06/06/24 (entry not timed) The facility nurse reported to the provider R1 was having mood swings, decreased appetite and refusing meals. The order to discontinue R1's Paxil was obtained. The order to change R1's Lorazepam anti-anxiety medication to be administered every afternoon and as needed twice if needed every eight hours obtained.

On 07/10/24 (entry not timed) The facility nurse reported to the provider an overall decline in R1's cognition and physical abilities. An order for an incontinent products provided due to R1's increased incontinence.

On 08/22/24 at 04:42 PM The facility nurse received a phone call that R1 had left the facility and walked down the facility driveway where she was found by the facility maintenance staff.

Interview on 09/03/24 at approximately 03:00 PM with Operator A confirmed the urinalysis obtained from the provider order dated 03/06/24 was negative for bacteria, she further confirmed the FCS was not performed for R1 when R1 started exhibiting a change in her behavior physical decline.

Review of the providers "Visit Notes" dated

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S3081	Continued From page 3 03/06/34 revealed the following statements in the section titled "Plan of Care": "Change in status: something is clearly different with patient. Obtain a urinalysis.." "Dementia with psychotic disturbance/anxiety/depression: short term memory loss is cycling every couple of minutes. No behaviors, managed on Buspar. Noted no orientation to self or place this day. Discontinue Aricept." The operator failed to ensure a screening was performed determining the functional capacity for R1 when she experienced a change of condition.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by:	S3092		

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S3092	Continued From page 4 K.A.R. 26-41-202 (d) (2) The facility reported a census of 20 residents. The sample included one "Resident" (R). Based on interview and record review the operator failed to ensure the Negotiated Service Agreement (NSA) for R1 was reviewed and if necessary revised when R1 scored as a moderate elopement risk on the facility's "Elopement Risk Assessment" on 10/31/23, and the Operator further failed to review and revise if necessary, R1's NSA when she experienced a change in her behavior and experienced a physical decline. Findings included: - Record review for R1 revealed an admission date of 04/13/22 with diagnoses of anxiety, dementia, anemia, and hypothyroidism. Review of R1's "Functional Capacity Screen" (FCS) dated 09/20/23 revealed R1 required supervision with bathing and dressing. R1 was scored with impaired short-term memory, long-term memory, memory recall, and decision making. She was usually able to make herself understood and she usually understood others. R1 was identified as having impaired hearing and inappropriate behavior. The FCS did not identify R1 as having wandering behavior. Review of R1's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 09/20/23 identified facility staff would provide supervision for bathing and prompts for dressing. In the section titled "Mentation" facility staff were instructed to provide prompts and	S3092		

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S3092	Continued From page 5	S3092		

reminders to complete task due to "forgetfulness and confusion." In the section titled "Behavior" it identified R1 as having confusion and forgetfulness being noted at times. Staff were instructed to provide one-on-one for reassurance due to anxiety.

Review of the facility's "Elopement Risk Assessment" dated 10/31/23 revealed R1 had a history of dementia, and she became confused outside the facility. She wandered within the facility but did not "Exit seek", and she lived in the assisted living and was a moderate risk for elopement.

The combined NSA/HSP did not identify health services for wandering behaviors.

Review of R1's "Resident Notes" dated 10/26/23 to 09/03/24 revealed the following entries:

On 01/10/23 (entry not timed) R1's daughter told the facility nurse she spoke to R1's provider about R1 having increased confusion when returning to the facility after going on an outing. The decision was made to change to a provider that would see the resident in the facility.

On 03/06/24 (entry not timed) The facility nurse reported to the provider R1 was having ear pain, she was having increased behaviors, episodes of crying, becoming frustrated, showing agitation towards staff and she was refusing to eat meals. Order for a urinalysis obtained.

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S3092	Continued From page 6	S3092		

medication to be administered every afternoon and as needed twice if needed every eight hours obtained.

On 07/10/24 (entry not timed) The facility nurse reported to the provider an overall decline in R1's cognition and physical abilities. An order for an incontinent products provided due to R1's increased incontinence.

On 08/22/24 at 04:42 PM The facility nurse received a phone call that R1 had left the facility and walked down the facility driveway where she was found by the facility maintenance staff.

Review of the providers "Visit Notes" dated 03/06/34 revealed the following statements in the section titled "Plan of Care":

"Change in status: something is clearly different with patient. Obtain a urinalysis.."

"Dementia with psychotic disturbance/anxiety/depression: short term memory loss is cycling every couple of minutes. No behaviors, managed on Buspar. Noted no orientation to self or place this day. Discontinue Aricept."

Interview on 09/03/24 at approximately 03:00 PM with Operator A confirmed the urinalysis obtained from the provider order dated 03/06/24 was negative for bacteria, she further confirmed the FCS was not performed for R1 when R1 started exhibiting a change in her behavior physical decline.

The operator failed to ensure the R1's NSA was reviewed and if necessary revised, when R1 scored as a moderate elopement risk on the

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S3092	Continued From page 7 facility's "Elopement Risk Assessment" on 10/31/23, and the Operator further failed to review and revise if necessary, R1's NSA when she experienced a change in her behavior and experienced a physical decline.	S3092		