

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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 represents the findings of an Abbreviated Licensure Survey with complaint investigations 186280, 186967, 185062, and 185088 for the above named assisted living facility conducted on 04/18/24 and 04/22/24.	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 69 residents (R). The sample included seven focus record reviews. Based on observation, interview, and record review for two (R3 and R5) of seven residents, the executive director failed to ensure both R3 and R5 were not subjected to neglect. For R5, the executive director failed to ensure staff were properly trained on elopement procedures, failed to include interventions for elopement in the resident's plan of care and failed to ensure staff provided adequate supervision and thoroughly looked outside in a timely manner after an exit door alarm triggered	S3026		

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

TITLE

(X6) DATE

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 1</p> <p>across employee pagers on 03/02/24. This failure placed the resident in immediate jeopardy for harm, injury, or possible death when he exited out an alarmed secure memory unit door and was unaccounted for approximately 30 minutes, until he was located 0.5 miles from the facility. For R3 the executive director failed to ensure care staff responded to her call light promptly after assisting her onto the toilet, leaving her to sit on the hard surface for over 30 minutes causing her lower back pain and hip discomfort. Findings included:</p> <p>- On 04/18/24 the facility identified 13 residents at risk for elopement, all living on the locked memory care unit. This included R5.</p> <p>Record review for R5 revealed an admission date of 6/14/23 with diagnosis of dementia.</p> <p>R5's admission "Functional Capacity Screen" (FCS) dated 06/14/23 identified he was independent with transfers, walking/mobility, did not use an assistive device, had impaired cognition, and had current problems of wandering and impaired decision-making abilities.</p> <p>R5's most recent FCS, dated 04/15/24, 31 days after he eloped, identified the resident remained independent with transfers and walking/mobility, did not use an assistive device, his cognition declined from a "3" to a "4", he had current problems with falls, wandering and impaired decision-making ability.</p> <p>R5's admission "Individualized Service Plan"</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 2</p> <p>(ISP - Negotiated Service Agreement) dated 06/28/23 included direction for staff to provide cueing, reminders to complete daily task and ambulated independently without an assistive devices. The ISP identified the resident was forgetful and became anxious at times and needed staff redirection and reassurance. It identified R5 at risk for elopement due to being a new resident and getting easily turned around. Staff were to supervise him when getting fresh air to ensure he did not leave the property unsupervised, monitor his location in the community to ensure his safety and safety of others, and reorient him to where his apartment and other areas were in the secured memory care unit.</p> <p>R5's most recent "Negotiated Service Agreement" dated 04/15/24, after he eloped on 03/02/24, included the same elopement risk interventions as the admission ISP completed on 06/28/23 except it included specific times to check the resident every two hours, on even hours. The NSA lacked revisions after R5 eloped on 03/02/24 regarding supervision, or personalized interventions to ensure R5 did not elope from the facility again due to continued exit seeking.</p> <p>Review of R5's "Mini-Mental State Examination" dated 06/15/23 revealed a score of three out of thirty indicting the resident had significant cognitive deficits.</p> <p>Review of R5's Elopement Risk Evaluation dated 06/15/23 had a score of 27 which indicated he was a high risk for elopement.</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 3</p> <p>Review of R5's "Observation Notes" (nursing notes) revealed the following:            02/26/24- Resident found in another resident's room asleep and was taken to his own room and 30 minutes later he was up again "exit seeking."            03/10/24 - resident refused to change soiled clothing and proceeded to go door to door looking for a place to go.            03/11/24 - resident left for behavior unit for evaluation and treatment.            04/04/24 - resident returned to the facility.            04/05/24 - Outside resource staff, let R5 and another resident out the door and facility staff redirected them back into the facility as they were going out. After R5 came back in the facility, he continued to exit seek.            04/05/24- Resident has slowed down and is not going as much door to door as he did first thing this morning.            04/06/24 - Resident walking to multiple doors trying to see if they will open. If continues will see if he will take medication for anxiety.            04/07/24- resident pushing on the exit doors and got very angry with nurse when asked to step away from the door and drew his fist back as if he was going to hit nurse.            04/07/24 - resident very unstable walking tonight.            04/08/24- resident was in another resident room and became aggressive with staff when attempting to change him. Staff later observed the resident coming out of the main kitchen area.            04/10/24- resident up wandering around carrying clothing on hangers.            04/11/24 - staff reported to nurse resident almost escaped three times this morning around breakfast time. "Other residents were eating breakfast at this time and there was no staff found on the unit during each incident with R5."</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 4</p> <p>Interview on 04/18/24 at 11:03 AM Certified Medication Aide (CMA) D reported, in the past few weeks R5 had been walking all over the place, wandering into other resident rooms and going to the doors trying to leave.</p> <p>Interview on 04/01/24 at 11:52 PM CMA C reported on 03/02/24 when R5 left the facility without staff knowledge the alarm on the back southeast door was quiet but came across the pagers. She reported the alarm is supposed to sound really loud when the door opened. The alarm did not sound so she just turned off the door alarm without looking outside. CMA C stated the alarm went off again about 15-20 minutes later and the alarm that was supposed to sound was not sounding until she opened the door and looked outside. CMA reported she did not see anyone and when she realized R5 was not around someone said they saw him down the street by a local store. That is when she and another employee left and went to get him. She added that if an alarm sounds, staff were supposed to go outside and check to make sure no one went out the door and staff are to start a head count to make sure all residents are in the building. CMA C reported after he (R5) left, the facility started having elopement drills and training to do a better response time to get to the doors.</p> <p>Observation of the area where R5 had walked, revealed a two-lane road with a center turn lane and a speed limit of 35 miles per hour. Each side of the road had sidewalks but on the other side was heavily brush area that was undeveloped. No crossing or stoplights are located on this</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 5</p> <p>section of road. For the resident to have been found inside the local store he would have had to cross all three lanes of traffic with a large hill possibly impeding his view of oncoming traffic. The weather at the time R5 was out of the facility was 71 degrees Fahrenheit. According to the facility report when the resident returned, he had "soiled" clothing and refused to allow staff to change him or take his vital signs.</p> <p>On 04/18/24 at 01:24 PM Maintenance Staff E reported nursing staff had reported to him, sometimes the big alarms do not sound but he had not noticed a concern when he checked them monthly.</p> <p>On 04/18/24 at 03:38 PM Administrative Staff A reported she believed staff had done everything except revising the care plan since R5 had not gotten out of the facility since 03/02/24. Administrative Staff A reported she put up a black curtain over the exit door, but he continued to mess with the door even with the curtain on it. Administrative Staff A looked for elopement drills conducted prior to 03/02/24 and reported she was not able to find any prior to R5's elopement.</p> <p>Review of the "Elopement Risk" policy and procedures updated 06/13/23 revealed all employees will receive ongoing in-service training on how to respond in the event of an elopement.</p> <p>Review of the "Missing Resident" policy and procedures updated 03/15/22 failed to direct staff on what to do if a door alarm sounds, indicating a resident may have exited out that door without staff supervision.</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 6</p> <p>The Executive Director failed to ensure the resident was not subjected to neglect when R5, who had poor decision-making ability, wandering episodes, was identified as an elopement risk, and exhibited exit seeking behavior just days prior, exited out the southeast door without staff knowledge and supervision and was located 0.5 miles away inside a local business. He had been unaccounted for approximately 30 minutes.</p> <p>The immediate jeopardy was abated on 04/18/24 at 5:10 PM when Administrative Staff A provided a plan for prevention of recurrence of elopement for this resident or any other resident identified at risk for elopement. The plan identified staff failed to respond to the door alarm timely and did not look out the door or conduct a resident count to ensure all residents were in the community. It also included the following plan of action:</p> <ol style="list-style-type: none"> <li>1. Missing Person policy will be updated to direct staff what to do when the door alarm pagers go off at the exit doors.</li> <li>2. Memory care exit doors to have daily shift checks added to building task and will be done daily for two weeks, then weekly for four weeks.</li> <li>3. Elopement drills will be conducted on all shifts by 04/20/24.</li> <li>4. The executive director will conduct weekly elopement drills for four weeks and then continue every month.</li> </ol> <p>- Review of R3's medical record revealed she moved into the facility on 04/03/23 with diagnoses of Parkinson's Disease, spinal stenosis, and low back pain.</p> <p>R3's admission "Functional Capacity Screen"</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 7</p> <p>dated 04/03/23 revealed she needed physical assistance with all activities of daily living except was independent with eating. She also had bladder incontinence, had no cognitive deficits and was able to understand others and make herself understood without any problems.</p> <p>R3's "Individualized Service Plan" (ISP-Negotiated Service Agreement) dated 04/17/23 directed staff to provide physical assistance with activities of daily living including toileting assistance. It also identified she was a fall risk and for staff to answer her call light or page from her pendant promptly due to risk for falls. It noted she was unsteady with ambulation and often felt like staff rushed her thus can get anxious at times when trying to walk.</p> <p>Review of the call light pendant reports from 01/06/24 to 01/09/24 included in the facility report, revealed the resident used her call light for assistance 25 times. Ten of those times the response time was greater than 10 minutes, with two times greater than 30 minutes: 01/07/24 at 10:13 am and again on 01/08/24 at 09:51 AM both for 33 minutes. The report included documentation from Administrative Staff A that included additional times on 01/06/24 resident was left on the toilet from 02:46 pm to 03:26 pm and on 01/07/24 from 02:25 PM to 02:54 PM CMA H had left R3 on the toilet per electronic monitoring review. The report conclusion was that CMA H was found not properly responding to resident cares and needs in a timely manner, when she left R3 on the toilet for a significant length of time before responding to her needs. This failure was a violation of the facility's Abuse, Neglect, and Exploitation prevention Policy.</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	<p>Continued From page 8</p> <p>Review of the call light logs provided by Administrative Staff A from 03/23/24 to 04/21/24 revealed the following call light time responses: R3 rang her call light 228 times with 114 times taking 10 minutes or longer for staff to respond to her needs. Sixty-eight of the times were greater than 15 minutes, 22 times were greater than 20 minutes, 11 times greater than 30 minutes, four times greater than 45 minutes, and one time it took 1.91 hours for staff to answer R3's call light.</p> <p>Interview on 04/22/24 at 03:30 PM, R3 reported she had a history of hip and back surgery and has pain a lot of the time. She stated she is supposed to be walking but staff tell her she really needs to use the wheelchair since she about lost her balance the other day. She also reported she still had concerns about staff taking so long to come and answer her call light and sitting on the toilet too long as well as waiting long periods to go to bed. She reported she has had to wait almost two hours after turning on her call light before someone came in to help her.</p> <p>Interview on 04/22/24 at 04:06 PM Certified Medication Aide F reported R3 has a lot of pain and staff needed to take things slow with her. She reported staff walked her to the toilet before bed, changed her clothing and then walked her to bed and got her comfortable for the night.</p> <p>Interview on 04/22/24 at 04:09 PM Certified Nurse Aide G reported they help with everything for R3 and try to always have two staff present when helping her because she does have a lot of pain. It can take longer if another staff is unavailable.</p>	S3026		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3026	Continued From page 9  Interview on 04/22/24 at 02:35 PM Administrative staff A confirmed CMA H was terminated and the allegation of staff not responding to the resident needs timely was substantiated. On 04/23/24 at 10:45 AM Administrative Staff A reported the goal is for call lights to be answered within five minutes of being triggered by the resident.  The executive director failed to ensure R3 was not subjected to neglect when staff failed to respond to her call light promptly, after assisting her onto the toilet, leaving her sit on the hard surface for over 30 minutes causing her lower back and hips to hurt.	S3026		
S3200 SS=G	26-41-205 (d) (1-2) Facility Administration of Medications  (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3200	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d)</p> <p>The facility reported a census of 69 residents (R). The sample included seven focused record reviews. Based on interview and record review the executive director failed to ensure designated staff administered medications according to a medical providers orders and standards of practice for one ( R4) of three residents who received anticoagulant therapy. This resulted in the resident having excessive bleeding that required hospitalization.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Review of R4's medical record revealed she moved into the facility on 06/06/23 with diagnosis of paroxysmal atrial fibrillation (rapid, irregular heartbeat).</li> </ul> <p>R4's admission "Functional Capacity Screen" dated 06/06/23 had coded the resident was independent with management of mediations and medical treatments.</p> <p>R4's admission "Individualized Service Plan" (ISP- Negotiated Service Agreement) dated 06/20/23 revealed Certified Medication Aide/Nurse administers/manages all medications per physician's order. Resident is on Coumadin and Home health company to provide blood work (INR) through the Coumadin Clinic.</p> <p>Review of R4's medical providers notes with</p>	S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3200	<p>Continued From page 11</p> <p>orders from 10/30/23 to 12/21/23 revealed the resident no longer took an anticoagulant due to recurrent falls.</p> <p>Review of the hospital discharge summary dated 01/07 023 revealed R4 was admitted to the local hospital for "Gross hematuria" (blood in urine), acute blood loss anemia, and Warfarin (anticoagulant) - induced coagulopathy. It revealed R4 had been hospitalized at the same hospital in August for a fall in which she sustained intracranial hemorrhage and was recommended at that time she discontinue warfarin due to recurrent falls. It identified that she had continued to receive warfarin until yesterday (1/4/24) with lab results of a hemoglobin of 7.1 and was a 10 in September 2023. Normal range for hemoglobin is 12-15. It noted that her INR ( International Normalized Ratio) was 9.55 (High Critical) on admission and was administered 10mg of vitamin K and her INR normalized. R4's hemoglobin dropped to 6.7 on 01/06/24 and was given a unit of Packed Red Blood Cells and her hemoglobin improved and did not require further transfusion. It identified R4's condition upon admission was serious and stable upon discharge.</p> <p>Review of R4's Medication Administration Records (MAR) in the first electronic record information, for October, November, December 2023 still included an order for Warfarin 3mg tablet one tablet daily by mouth for atrial fibrillation, but staff documented with an "S" indicating the order is suspended.</p> <p>Review of the current electronic medical records system MARs revealed the following:</p>	S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3200	<p>Continued From page 12</p> <p>December 2023 MAR she received warfarin 23 out of 31 possible times with 3 times documented resident refused, 2 times documented not applicable, one time documented discontinued, another time to see nurses notes and one time had no documentation.</p> <p>January 2024 MAR she received warfarin on 01/01/24 and 01/02/24, it was held on the 3rd, 4th, 5th, and 6th and then discontinued.</p> <p>Review of R4's medical record did not include an order to resume Warfarin after she returned from the hospital in August status post cranial hemorrhage.</p> <p>Review of R4's observation nursing notes revealed the following: 01/04/24 -Coumadin on hold d/t resident had bit tongue and bleeding is in excess, medical provider notified and order to place medication (Warfarin) on hold and obtain Lab. 01/05/24 at 1:45 PM -Resident called regarding a urine sample and observation revealed dark red blood in the specimen hat. 01/05/24 at 2:00 PM - R4 has been bleeding via her urine with numerous clots noted, voiding in very small amounts, and R4's legal representative has been updated throughout the day, will on his way to the facility. The next note on 01/06/24 identified the resident was in the hospital and had received blood transfusions.</p> <p>On 04/22/24 at 01:08 PM Administrative Staff A reported when the facility changed electronic medical records, including the MAR, whoever put the orders in for R4 put in orders that included taking Warfarin 3mg daily. In our investigation</p>	S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>N089069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CEDARHURST OF TOPEKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6732 SW 17TH STREET TOPEKA, KS 66615</b>
---	--

(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
S3200	<p>Continued From page 13</p> <p>the Warfarin card had been put in the "to be destroyed" drawer and someone pulled it back out and put it in the cart for staff to administer.</p> <p>The Executive Director failed to ensure staff administered medications for R4 according to physicians' instructions which resulted in R4 receiving Warfarin, an anticoagulant, causing her blood to thin significantly to where she became anemic due to excessive blood loss resulting in hospitalization and the need for a blood transfusion.</p>	S3200		