STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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 resurvey with complaint #105599 at the above named facility on 2-9-17, 2-13-17, 2-14-17, 2-15-17, 2-16-17, and 2-20-17. Revised 2567 sent to facility 2-20-17	S 000		
S3026 SS=F	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 identified a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on record review, observation, and interview for 1 (#100) of 3 residents sampled with the potential to affect all residents, the operator failed to ensure residents were not subjected to neglect when the licensed nurse failed to implement interventions for a cognitive impaired resident who exhibited signs and symptoms of parasites and further failed to provide information and education to staff to prevent the spread of parasites. Findings included:	S3026		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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 1 - Record review for resident #100 on 2-9-17 revealed an admit date of 2-6-15 with diagnoses of dementia, atrial fibrillation, macular degeneration, congestive heart failure, and frequent urinary tract infections. The annual Functional Capacity Screen (FCS) no date (3-11-16) recorded resident independent with transfer, walking/mobility, eating, communication, required physical assistance with bathing, dressing, toileting, incontinent of bowel and bladder control, unable to manage medications/treatments, experienced impaired short term memory long term memory, memory recall, and decision making. Current or recent problems included falls/unsteadiness. . Mobility device: walker. The annual Negotiated Service Agreement (NSA) dated 3-11-16 recorded standard emergency call system is provided to access staff twenty-four hours a day, Weekly room cleaning, facility staff to store and administer all medications, remind/cue, standby assistance getting into and out of shower, total assist by staff for shower two times a week. Resident independent with transfers, mobility: uses bed cane. Resident required physical assist with grooming, nail care, staff assistance with management of incontinent bladder control, assist with care or change of undergarment. Assist with trash for incontinent products. Resident has short term memory loss, long term memory loss and forgetfulness. Nightly bed checks every 2 hours. The amended HCSP dated 4-6-16 recorded facility staff administer medications daily, lab monitoring as ordered by physician, behavior/cognition support: Bathing: Assist with	S3026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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 2	S3026		

gathering washing items and wash cloth; assist into and out of bath; give verbal reminders and encouragement during shower; monitor skin integrity during shower and report concerns to nurse; give hands on assist two times a week with bathing; assist with grooming verbal reminders and encouragement with dressing; toileting: independent; incontinent of bladder; wears depends; assist with incontinence products; empty trash of soiled incontinence products every shift; independent with walker for transfer and mobility; bed checks every two hours at night. Empty trash daily, make bed daily.

The record contained a written physician ' s order dated 10-17-16 for pinworm two and one half teaspoons once and may repeat in two weeks. Noted by licensed nurse A.

The Medication Administration Record (MAR) dated 10-18-16 recorded, " pin worm two and one half teaspoons now and may repeat in two weeks. "

The nurses notes recorded the following:

10-13-16 at 10:00 a.m., " Staff (licensed nurse A could not recall all staffs names) who reported worms in feces and put in a urinalysis cup. One and a half inches long. Physician ' s office notified. " Signed licensed nurse A.

10-17-16 at 3:15 p.m., " Resident has worms in feces. Pin worm two and one half teaspoons one time now - may repeat in two weeks. " Sign licensed nurse A.

The record lacked clarification of order that said " may repeat in two weeks " and lacked follow up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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 3	S3026		

assessment and rationale for decision not to repeat medication in 2 weeks.
Interview on 2-14-17 at 9:45 a.m. with licensed nurse A stated certified staff J sent him/her a picture and stated observed worms in large loose bowel movement. He/she put worms in a urinalysis cup and put on licensed nurse A ' s desk. He/she also took a picture of worms left inside washing machine after washing clothes. This was on 10-12-16 at 11:47 a.m. The worms were also on bed pad and under garments. Licensed nurse A further stated resident had an incontinent episode. Resident was cleaned up, family and physician was notified on 10-13-16. The physician ordered a stool sample and Pin worm two and one half teaspoons administered on 10-18-16. May repeat in two weeks. They put a hat in resident ' s toilet but resident refused to use it so a stool sample was not obtained. On 11-2-16 second dose of Pin worm was going to be administered but resident refused and licensed nurse A did not want to repeat second dose since did not see worms in feces. Licensed nurse A stated no other residents had worms noted in feces. Licensed nurse A also stated he/she did not have a clue what pin worms looked like or what they are. Resident #100 ' s room was cleaned with bleach by housekeeper but Licensed nurse A did not know which housekeeper cleaned the room and further stated he/she did not document anything about pin worms, did not implement any interventions to prevent the spread of parasites, or amend the HCSP. Licensed nurse A stated he/she would have to educate self on pin worms and was not aware of any interventions that should have been implemented for anyone with pin worms.

Interview on 2-13-17 at 2:05 p.m. with certified staff K stated had worked here for over a year

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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 4	S3026		

and resident #100 is incontinent of bowel and bladder. Resident is combative and hits at staff. Certified staff K stated he/she was never informed resident had pin worms and confirmed care plan lacked interventions for care of resident with parasites.

On 2-13-17 at 12:00 noon observed resident #100 in bed using cane rail to reposition self. Resident complained of pain in abdomen. Licensed nurse A asked if he/she wanted a cookie. Licensed nurse A stated he/she had staff take resident to memory care unit to eat meals because it is a lot quieter in the unit and more one on one staff to provide assistance.

Interview on 2-13-17 at 4:00 p.m. with licensed nurse H stated he/she heard about pin worms and knew that a stool specimen was not sent in due to resident being noncompliant.

Interview on 2-13-17 at 4:05 p.m. with certified staff I stated provided incontinent care to resident #100 as he/she is incontinent of bowel and bladder. He/she stated worked at facility when pin worms identified but did not see any parasites, was not instructed to provide care in a different way, and was not in-serviced about pin worms or parasite control.

Center for Disease Control (CDC) pinworm infection prevention and control documents: " Washing your hands with soap and warm water after using the toilet, changing diapers, and before handling food is the most successful way to prevent pinworm infection. In order to stop the spread of pinworm and possible re-infection, people who are infected should bathe every morning to help remove a large amount of the eggs on the skin. Showering is a better method

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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 5 than taking a bath, because showering avoids potentially contaminating the bath water with pinworm eggs. Also, infected people should comply with good hygiene practices such as washing their hands with soap and warm water after using the toilet, . . and before handling food. They should also cut fingernails regularly, and avoid biting the nails and scratching around the anus. Frequent changing of underclothes and bed linens first thing in the morning is a great way to prevent possible transmission of eggs in the environment and risk of reinfection. These items should not be shaken and carefully placed into a washer and laundered in hot water followed by a hot dryer to kill any eggs that may be there. " For resident #100, with the potential to affect all residents, the operator failed to ensure residents were not subjected to neglect when the licensed nurse failed to implement interventions for a cognitive impaired resident who exhibited signs and symptoms of parasites and further failed to provide information and education to staff to prevent the spread of parasites.	S3026		
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	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(B)(C)(D)(E)(F) The facility identified a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on observations, record reviews and interviews for 3 (#100, #100, #300) of 3 residents sampled, the operator failed to report allegation of abuse, neglect, or exploitation to the department within 24 hours. The operator also failed to ensure an investigations started upon notification, take immediate measure to prevent further potential abuse, neglect, or exploitations while investigation in progress, conduct a thorough investigation with in five working days of initial report, implement appropriate corrective action if alleged violation is verified, complete and submit the Department's complaint investigation report within five working days of the initial report, and a record shall be	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 7	S3028		

maintained of each investigation of the reported abuse, neglect, or exploitation.

Findings included:

- Record review for resident #100 on 2-9-17 revealed an admit date of 2-6-15 with diagnoses of dementia, atrial fibrillation, macular degeneration, congestive heart failure, and frequent urinary tract infections.

The admission FCS dated 7-15-15 recorded resident independent with transfer, walking/mobility, required supervision with toileting, physical assistance with bathing, experienced impaired short term memory, memory recall, and decision making. Current or recent problems included falls/unsteadiness. Resident uses a walker for mobility device.

The admission NSA/HCSP dated 7-15-15 included two hour checks for safety, remind to call for help, ensure call light is in reach.

The amended HCSP dated 4-6-16 included fall interventions: remind to call for help; ensure call light is in reach; communication needs: use slow verbal cues; provide extra time for response to ensure resident needs are met; bed checks every two hours at night.
The annual Functional Capacity Screen (FCS) no date (3-11-16) recorded resident now required physical assistance with toileting and experienced impaired short term memory, long term memory, memory recall, decision making, and continued to list falls/unsteadiness as a current or recent problem.

The annual Negotiated Service Agreement (NSA) dated 3-11-16 Resident independent with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 8	S3028		

transfers, mobility: uses bed cane. Resident has short term memory loss, long term memory loss and forgetfulness. Nightly bed checks every 2 hours.

The annual HCSP (no date) recorded independent with walker for transfer and mobility; fall interventions: remind to call for help; ensure call light is in reach; communication needs: use slow verbal cues; provide extra time for response to ensure resident needs are met; bed checks every two hours at night.

The nurses notes recorded the following unwitnessed falls:
12-21-16 at 8:00 p.m. resident found on floor, bumped head, hematoma to back of head. Fell out of bed and hit head on night stand.
1-6-16 at 7:15 p.m. resident found lying on floor in doorway of room/hall with walker at side. Resident stated did not know where he/she was going. Observed golf ball hematoma with abrasion to left side of eye. Alert but confused. Sent to emergency room.

2-23-16 at 8:00 p.m. resident found on floor with walker.

3-1-16 at 5:00 p.m. resident found on knees in front of toilet. Unwitnessed fall. Resident did not use call light for assistance.

7-19-16 at 8:15 p.m. resident fell. No injuries noted.

8-2-16 at 10:00 a.m. resident found sitting in shower.

9-23-16 at 12:10 p.m. resident found on floor, confused, no injury noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 9 11-21-16 at 3:00 a.m. resident was found on floor near his/her bed. Reported rolled out of bed. 11-27-16 at 6:55 a.m. resident found on floor. Resident stated rolled out of bed. 1-27-17 at 10:00 a.m. resident found on floor. Resident stated rolled out of bed. A bed cane will be placed to prevent from rolling out of bed. Interview on 2-13-17 with certified staff I stated resident required one person assist for toileting and getting ready for bed. Resident is hard to redirect and he/she gets frustrated easily. Certified staff I checked the HCSP and confirmed it did not have anything written about behaviors and he/she will not always use the call light. 2-14-17 at 9:45 a.m. with licensed nurse A stated and confirmed the HCSP recorded for cognitive impaired resident to use call light for help and staff to ensure call light in reach. Bed cane in place. Resident #100 experienced 10 unwitnessed falls, 2 with head injuries, 1 required an emergency room visit due to large hematoma and increased confusion. Records lacked documentation of reports or investigation of falls. For resident # 100, the operator failed to report allegation of abuse or neglect to the department within 24 hours and investigate the unwitnessed falls of this cognitive impaired resident. - Record review for resident #200 revealed an admit date of 5-15-15 with diagnosis of coronary artery disease, hypertension, and back pain.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 10	S3028		

The admission FCS dated 7-15-15 recorded resident independent with walking/mobility, transfer, required supervision for toileting, experienced short term memory loss, impaired memory recall, and decision making, and listed falls/unsteadiness as a current or recent problem. Use walker for ambulation.

The initial NSA/HCSP dated 7-15-15 included fall interventions: two hour checks for safety, remind to call for help, and ensure call light in reach.

The annual FCS dated 8-9-16 recorded resident #200 continued to identify no falls in last 180 days.

The annual NSA dated 8-9-16 and annual HCSP (no date) identified no changes in services

The nurses notes recorded the following falls:

10-13-15 at 7:00 a.m. unwitnessed fall near bed. Resident unsure how or why.

10-15-15 at 7:11 p.m. unwitnessed fall. Resident reported he/she misjudged where recliner was and lowered self to floor.

3-21-16 at 1:45 a.m. a written statement from certified staff S (for unwitnessed fall) recorded heard someone yelling, went to room and observed resident on floor. Resident stated he/she slid off bed. No complaint of pain other than knees are sore.

4-17-16 at 5:00 p.m. a "Fall Investigation Report" recorded resident was at high risk for fall. Unwitnessed fall in resident room. Left elbow had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 11	S3028		

skin tear and a hematoma to top of head.

A written statement from certified staff P dated 4-17-16 recorded at 5:05 p.m. another resident called to tell us that somebody needed help. I went to room next to him/her and found (resident #200) lying on right side with feet facing the foot of the bed. The walker was tipped over by feet. Resident ' s head was by the cabinet at the kitchenette. I got certified staff Q and he/she took vital signs and notified licensed nurse R and informed him/her resident had a skin tear and hematoma a nickel size on head. Licensed nurse R stated we could get resident up and assisted up to feet.

A written statement dated 4-17-16 from certified staff Q stated certified staff P informed him/her that resident (#200) was found on floor. . . observed a skin tear and a hematoma on head. Ice packs applied every twenty minutes. Licensed nurse R was notified prior to getting resident up. Blood Pressure (B/P) 153/80, Pulse (P) 83, and Temperature (T) 97.5, oxygen saturation 94%.

Nurses notes further recorded
4-24-16 at 3:50 a.m. a "Fall Investigation Report: recorded resident high risk for fall. (Unwitnessed fall) Accident report recorded resident rolled out of bed and was found during rounds on the floor yelling for help.

6-8-16 at 7:30 p.m. resident found sitting on floor in bathroom. Resident stated tried to stand and fell to floor. Small bruise observed to lower back.

6-10-16 at 10:22 p.m. resident found by staff lying on floor by bed. Resident placed on 30 minute checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 12 8-30-16 at 4:20 a.m. unwitnessed fall, resident found on the floor with walker in front of him/her. No injuries. 9-2-16 at 12:00 noon, resident found in dining room on floor lying on back. Another resident stated resident was going to sit in chair, missed and fell backwards and hit head. Blood pressure 170/102, pulse 95, respirations 20. Resident was unconscious and seemed to be choking. Rolled resident on side and Emergency Medical Services (EMS) notified. Resident started becoming conscious and when asked if he/she knew where he/she was, "he/she stated the beauty shop. Large hematoma to back of head. Denied pain except to back of head. EMS here to take resident to hospital. Interview on 2-13-17 at 4:40 p.m. with licensed nurse A stated, "(Resident #200) was on floor and staff yelled at him/her to come to dining room. He/she was informed resident missed sitting in chair, fell backwards and hit head. Resident seemed to be choking, rolled on side. Resident was unconscious and came to. I asked resident if he/she knew where he/she was and he/she stated the beauty shop. Observed a large hematoma approximately 2 centimeters on back of head. Resident stated was very nauseated, pupils was sluggish, called EMS and sent to hospital. I heard he/she had a brain bleed and was no longer able to do things for self. I went to hospital to assess resident and it was determined to send resident to a skilled nursing facility. Resident #200 experienced 9 falls 3 with injuries and 1 required hospitalization due to brain bleed and transferred to a skilled facility.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 13 For resident # 200, the operator failed to report allegation of abuse or neglect to the department within 24 hours and thoroughly investigate the unwitnessed falls of this cognitive impaired resident. - Record review for resident #300 revealed an admit date of 10-27-15 with diagnoses of dementia, anxiety and hypertension. The FCS dated 10-27-15 recorded resident independent with toileting, transfer, physical assistance with walking/mobility, experienced short term memory loss, impaired memory recall, long term memory, and decision making. Current or recent problems included falls/unsteadiness. Resident uses a walker. The NSA/HCSP dated 10-27-15 included stand by assistance when ambulating to and from dining area, independent in room. Fall interventions: remind to call for help and ensure call light is in reach. The FCS dated 11-28-16 recorded resident now physical assistance with toileting, transfer, walking/mobility, and continued to identify falls/unsteadiness as a current or recent problem. The NSA/HCSP dated 11-28-16 recorded resident now required physical assistance of one person for transfer, uses 4 wheeled walker and stand by assist, in memory care unit, short term memory loss, long term memory loss, forgetfulness, disorientation to time, place, date, difficulty in communicating needs at times, and nightly bed checks every two hours. Amended NSA on 1-16-17 bed alarm.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 14	S3028		

The nurses notes recorded the following falls:

1-11-16 at 3:33 p.m. licensed nurse R was notified resident was found on floor next to recliner.

1-24-16 at 2:45 a.m. licensed nurse T was notified that resident was found on floor on bottom with legs extended toward toilet. Resident stated fell while trying to pull pants up. Resident complained of head hurting because he/she hit it on the floor. Hematoma present on left upper forehead. Skin tear to left upper forearm 3 Centimeters (CM) by 7 CM. Abrasion to left hand with two lacerations. Left knee has an abrasion. B/P 162/92, P 85, R 18. Ice pack applied to forehead. Family and hospice notified.

9-29-16 at 10:30 a.m. resident found on floor beside bed. Pajamas are silk and slippery against bed pad. Resident complained of pain in right hip. Licensed nurse A assisted resident back to bed.

10-16-16 at 10:50 staff reported a fall; resident stated was trying to get up. No complaints of pain.

11-21-16 at 10:00 p.m. Resident found on floor in bedroom. It is unknown how it happened. Denied pain.

12-31-16 at 5:30 a.m. Resident was found on floor next to bed with feet facing bathroom. Resident call light attached to shirt. Resident last checked at 4:30 a.m.

1-16-17 Resident fell at 12:20 a.m. and was found on the floor next to bed with the call light

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 15	S3028		

still clipped to shirt but not on. Licensed nurse R notified the family and physician.

Resident #300 experienced 7 unwitnessed falls.

On 2-14-17 at 9:30 a.m. observed resident #300 ambulating with certified staff F and walker. Resident ambulating at a slow pace with walker. Resident is in a cheerful mood.

Interview on 2-14-17 at 9:45 a.m. with certified staff F stated resident now has a pad alarm in bed and when he/she starts moving they can check on him/her. Resident is forgetful and forgets to use call light.

Interview on 2-14-17 at 11:20 a.m. with licensed nurse A stated and confirmed the HCSP identified resident experienced impaired cognition and recorded to have resident use call light for assistance.

For resident # 300, the operator failed to report allegation of abuse or neglect to the department within 24 hours and thoroughly investigate the unwitnessed falls of this cognitive impaired resident.

For residents #100, #200, and #300, the operator failed to report allegation of abuse, neglect, or exploitation to the department within 24 hours. The operator also failed to ensure an investigations started upon notification, take immediate measure to prevent further potential abuse, neglect, or exploitations while investigation in progress, conduct a thorough investigation with in five working days of initial report, implement appropriate corrective action if alleged violation is verified, complete and submit the Department's complaint investigation report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3028	Continued From page 16 within five working days of the initial report, and a record shall be maintained of each investigation of the reported abuse, neglect, or exploitation.	S3028		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility identified a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on record review, interview, and observation for 3 (#200, #100, #300) of 3 residents sampled, the operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services for falls of cognitively impaired residents. Resident #200 experienced 8 falls between 10/13/15 and 8/30/16 with no interventions to address his/her ongoing fall risk. On 9/2/16 resident #200 experienced a fall that resulted in a head injury which required hospitalization for a brain bleed and transfer to a skilled nursing facility. Findings included:	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 17 - Record review for resident #200 revealed an admit date of 5-15-15 with diagnoses of coronary artery disease, hypertension, and back pain. The admission FCS dated 7-15-15 recorded resident independent with walking/mobility, transfer, required supervision for toileting, experienced short term memory loss, impaired memory recall, and decision making, and listed falls/unsteadiness as a current or recent problem. Use walker for ambulation. The initial NSA/HCSP dated 7-15-15 included fall interventions: two hour checks for safety, remind to call for help, and ensure call light in reach. The nurses notes recorded the following falls: 10-13-15 at 7:00 a.m. unwitnessed fall near bed. Resident unsure how or why. 10-15-15 at 7:11 p.m. unwitnessed fall. Resident reported he/she misjudged where recliner was and lowered self to floor. 3-21-16 at 1:45 a.m. a written statement from certified staff S (for unwitnessed fall) recorded heard someone yelling, went to room and observed resident on floor. Resident stated he/she slid off bed. No complaint of pain other than knees are sore. 4-17-16 at 5:00 p.m. a "Fall Investigation Report" recorded resident was at high risk for fall. Unwitnessed fall in resident room. Left elbow had skin tear and a hematoma to top of head. 4-24-16 at 3:50 a.m. a "Fall Investigation Report: recorded resident high risk for fall. (Unwitnessed	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 18	S3155		

fall) Accident report recorded resident rolled out of bed and was found during rounds on the floor yelling for help.

6-8-16 at 7:30 p.m. resident found sitting on floor in bathroom. Resident stated tried to stand and fell to floor. Small bruise observed to lower back.

6-10-16 at 10:22 p.m. resident found by staff lying on floor by bed. Resident placed on 30 minute checks.

The annual FCS dated 8-9-16 recorded resident #200 continued to identify no falls in last 180 days.

The annual NSA dated 8-9-16 and annual HCSP (no date) identified no changes in services Resident #200 experienced 7 falls in 8 months and the only intervention listed on the NSA/HCSP to address this cognitively impaired resident ' s risk for falls was to remind to call for help and ensure call light is within reach.

8-30-16 at 4:20 a.m. unwitnessed fall, resident found on the floor with walker in front of him/her. No injuries.

9-2-16 at 12:00 noon, resident found in dining room on floor lying on back. Another resident stated resident was going to sit in chair, missed and fell backwards and hit head. Blood pressure 170/102, pulse 95, respirations 20. Resident was unconscious and seemed to be choking. Rolled resident on side and Emergency Medical Services (EMS) notified. Resident started becoming conscious and when asked if he/she knew where he/she was, "he/she stated the beauty shop. Large hematoma to back of head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 19	S3155		

Denied pain except to back of head. EMS here to take resident to hospital.

Interview on 2-13-17 at 4:40 p.m. with licensed nurse A stated, "(Resident #200) was on floor and staff yelled at him/her to come to dining room. He/she was informed resident missed sitting in chair, fell backwards and hit head. Resident seemed to be choking, rolled on side. Resident was unconscious and came to. I asked resident if he/she knew where he/she was and he/she stated the beauty shop. Observed a large hematoma approximately 2 centimeters on back of head. Resident stated was very nauseated, pupils was sluggish, called EMS and sent to hospital. I heard he/she had a brain bleed and was no longer able to do things for self. I went to hospital to assess resident and it was determined to send resident to a skilled nursing facility. "

Resident #200 experienced 7 falls including 2 with injuries prior to an annual update of the NSA/HCSP. The HCSP continued to lack appropriate interventions to address this cognitively impaired resident ' s risk for falls. He/she experienced 2 more falls, including a fall that resulted in a head injury that required hospitalization due to brain bleed and transfer to a skilled facility.

For resident #200, the operator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services for falls of cognitive impaired residents.

- Record review for resident #100 on 2-9-17 revealed an admit date of 2-6-15 with diagnoses of dementia, atrial fibrillation, macular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 20	S3155		

degeneration, congestive heart failure, and frequent urinary tract infections.

The admission FCS dated 7-15-15 recorded resident independent with transfer, walking/mobility, required supervision with toileting, physical assistance with bathing, experienced impaired short term memory, memory recall, and decision making. Current or recent problems included falls/unsteadiness. Resident uses a walker for mobility device.

The admission NSA/HCSP dated 7-15-15 included two hour checks for safety, remind to call for help, ensure call light is in reach.

The annual Functional Capacity Screen (FCS) no date (3-11-16) recorded resident now required physical assistance with toileting and experienced impaired short term memory, long term memory, memory recall, decision making, and continued to list falls/unsteadiness as a current or recent problem.

The annual Negotiated Service Agreement (NSA) dated 3-11-16 Resident independent with transfers, mobility: uses bed cane. Resident has short term memory loss, long term memory loss and forgetfulness. Nightly bed checks every 2 hours.

The annual HCSP (no date) recorded independent with walker for transfer and mobility; fall interventions: remind to call for help; ensure call light is in reach; communication needs: use slow verbal cues; provide extra time for response to ensure resident needs are met; bed checks every two hours at night.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 21	S3155		

The amended HCSP dated 4-6-16 included fall interventions: remind to call for help; ensure call light is in reach; communication needs: use slow verbal cues; provide extra time for response to ensure resident needs are met;

The nurses notes recorded the following unwitnessed falls:
12-21-16 at 8:00 p.m. resident found on floor, bumped head, hematoma to back of head. Fell out of bed and hit head on night stand.
1-6-16 at 7:15 p.m. resident found lying on floor in doorway of room/hall with walker at side. Resident stated did not know where he/she was going. Observed golf ball hematoma with abrasion to left side of eye. Alert but confused. Sent to emergency room.

2-23-16 at 8:00 p.m. resident found on floor with walker.

3-1-16 at 5:00 p.m. resident found on knees in front of toilet. Unwitnessed fall. Resident did not use call light for assistance.
The HCSP lacked interventions to address resident ' s ongoing risk for falls

7-19-16 at 8:15 p.m. resident fell. No injuries noted.

8-2-16 at 10:00 a.m. resident found sitting in shower.

9-23-16 at 12:10 p.m. resident found on floor, confused, no injury noted.

11-21-16 at 3:00 a.m. resident was found on floor near his/her bed. Reported rolled out of bed.

11-27-16 at 6:55 a.m. resident found on floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 22 Resident stated rolled out of bed. 1-27-17 at 10:00 a.m. resident found on floor. Resident stated rolled out of bed. A bed cane will be placed to prevent from rolling out of bed. Interview on 2-13-17 with certified staff I stated resident required one person assist for toileting and getting ready for bed. Resident is hard to redirect and he/she gets frustrated easily. Certified staff I checked the HCSP and confirmed it did not have anything written about behaviors and he/she will not always use the call light. 2-14-17 at 9:45 a.m. with licensed nurse A stated and confirmed the HCSP recorded the only interventions to address risk for falls for this cognitive impaired resident was to use call light for help and staff to ensure call light in reach. Bed cane in place. Resident #100 experienced unwitnessed 10 falls, 2 with head injuries, 1 required an emergency room visit due to large hematoma and increased confusion. The HCSP lacked interventions for a cognitive impaired resident to address ongoing risk for falls. For resident #100, the operator failed to ensure the licensed nurse provided and coordinated the provision of necessary health care services for falls of cognitive impaired residents - Record review for resident #300 revealed an admit date of 10-27-15 with diagnoses of dementia, anxiety and hypertension. The FCS dated 10-27-15 recorded resident independent with toileting, transfer, physical	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 23	S3155		

assistance with walking/mobility, experienced short term memory loss, impaired memory recall, long term memory, and decision making. Current or recent problems included falls/unsteadiness. Resident uses a walker.

The NSA/HCSP dated 10-27-15 included stand by assistance when ambulating to and from dining area, independent in room. Fall interventions: remind to call for help and ensure call light is in reach.

The nurses notes recorded the following falls:

1-11-16 at 3:33 p.m. licensed nurse R was notified resident was found on floor next to recliner.

1-24-16 at 2:45 a.m. licensed nurse T was notified that resident was found on floor on bottom with legs extended toward toilet. Resident stated fell while trying to pull pants up. Resident complained of head hurting because he/she hit it on the floor. Hematoma present on left upper forehead. Skin tear to left upper forearm 3 Centimeters (CM) by 7 CM. Abrasion to left hand with two lacerations. Left knee has an abrasion. B/P 162/92, P 85, R 18. Ice pack applied to forehead. Family and hospice notified.

9-29-16 at 10:30 a.m. resident found on floor beside bed. Pajamas are silk and slippery against bed pad. Resident complained of pain in right hip. Licensed nurse A assisted resident back to bed.

10-16-16 at 10:50 staff reported a fall; resident stated was trying to get up. No complaints of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 24	S3155		

pain.

11-21-16 at 10:00 p.m. Resident found on floor in bedroom. It is unknown how it happened. Denied pain.

The FCS dated 11-28-16 recorded resident now required physical assistance with toileting, transfer, walking/mobility, and continued to identify falls/unsteadiness as a current or recent problem.

The NSA/HCSP dated 11-28-16 recorded resident now required physical assistance of one person for transfer, uses 4 wheeled walker and stand by assist, in memory care unit, short term memory loss, long term memory loss, forgetfulness, disorientation to time, place, date, difficulty in communicating needs at times, and nightly bed checks every two hours.

Nurses notes further recorded
12-31-16 at 5:30 a.m. Resident was found on floor next to bed with feet facing bathroom. Resident call light attached to shirt. Resident last checked at 4:30 a.m.

1-16-17 Resident fell at 12:20 a.m. and was found on the floor next to bed with the call light still clipped to shirt but not on. Licensed nurse R notified the family and physician.
Amended NSA on 1-16-17 bed alarm.

On 2-14-17 at 9:30 a.m. observed resident #300 ambulating with certified staff F and walker. Resident ambulating at a slow pace with walker. Resident is in a cheerful mood.

Interview on 2-14-17 at 9:45 a.m. with certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3155	Continued From page 25 staff F stated resident now has a pad alarm in bed and when he/she starts moving they can check on him/her. Resident is forgetful and forgets to use call light. Interview on 2-14-17 at 11:20 a.m. with licensed nurse A stated and confirmed the HCSP identified resident experienced impaired cognition and recorded to have resident use call light for assistance. For residents #200, #100 and #300, the operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services for falls of cognitively impaired residents. Resident #200 experienced 8 falls between 10/13/15 and 8/30/16 with no interventions to address his/her ongoing fall risk. On 9/2/16 resident #200 experienced a fall that resulted in a head injury which required hospitalization for a brain bleed and transfer to a skilled nursing facility.	S3155		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto;	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3248	Continued From page 26 (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(1)(2) The facility identifed a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on 2 (L and N) of 5 employee records reviewed, the operator failed to ensure the records contained supporting documentation of certification and criminal background checks. Findings include: - Personnel records reveiwed on 2-14-17 at 12:10 p.m. with operator stated and confirmed unable to locate the registry and criminal back ground checks for certified staff L and N. For certifed staff L and N, the operator failed to ensure the records contained supporting documentation of certification and criminal background checks.	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3298	Continued From page 27	S3298		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (d) The facility census equaled 37 residents. The sample included 3 residents and 1 closed record review. Based on record review, interview and observations for all residents the operator failed to ensure all food prepared using safe methods that conserved the nutritive valuse, flavor, and appearance and shall be served at the proper temperature. Findings included: Review of food temperature logs lacked entries since the first of December 2016.	S3298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3298	Continued From page 28 Interview on 2-9-17 at 11:30 a.m. with dietary supervisor D provided stated, "(His/Her) thermometer has been broken since December and had not checked food temperatures." Licensed nurse A called the operator and asked if he/she could go get working thermometers. On 2-9-17 at 12:10 p.m. dietary supervisor stated he/she had two working thermometers now and lunch being served. The baked ham temperature recorded 180 degrees Fahrenheit (F), scalloped potatoes 186 degrees F, and carrots 147 degrees F. For all residents, the facility staff failed to prepare food using safe methods and served at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility census equaled 37 residents. The sample included 3 residents and 1 closed record review. Based on observation and interview, for all residents, the facility staff failed to store all food under safe and sanitary conditions.	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3299	Continued From page 29 Findings included: - Tour of kitchen on 2-9-17 at 10:35 a.m. with licensed nurse A revealed an open plastic bag of thin sliced ham with no date, a bag of white cream not sealed, dated, or labeled, a large bag of open chips without date opened, a gallon container of approximately on fourth of the gallon containing soy sauce lacked date opened and a plastic bag with frozen fish patties not dated or labeled. Licensed nurse A stated and confirmed food items not labeled or dated. For all residents, the facility staff failed to store all food under safe and sanitary conditions.	S3299		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by:	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	C 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

(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
S3310	Continued From page 30 KAR 26-41-207(c) The facility identified a census of 37 residents. The sample included 3 residents and 1 closed record review. Based on 4 (#J, #M, #N, #O) of 5 personnel records reviewed, the operator failed to ensure the facility's compliance with the department's Tuberculosis (TB) guidelines for adult care homes per K.A.R. 26-39-105. Findings included: - Review of personnel records on 2-14-17 at 12:10 p.m. with the operator revealed certified staff #J hired on 9-13-16, certified staff #M hired on 4-4-16, certified staff #N hired on 12-1-16 and staff #O hired on 8-9-16 lacked a two-step TB skin test. Interview on 2-14-17 at approximately 12:15 p.m. with the operator stated and confirmed the records lacked a two-step TB skin test. For personnel #J, #M, #N, and #O, the operator failed to ensure the facility's compliance with the department's TB guidelines for adult care homes per K.A.R. 26-39-105.	S3310		