STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023024	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EUDORA	2725 CHURCH ST EUDORA, KS 66025

(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 the licensure resurvey with attached complaint numbers; 177171, 174749, 174610, 173147, 170017, and 169971, for the above named facility conducted on 04/18/23 and 04/19/23.	S 000		
S3015 SS=F	26-41-101 (c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the facility; (2) implementing operational policies and procedures for the facility; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (c) (3) The facility reported a census of 47 residents. Based on observation and interview the operator failed to put in writing authorization of a responsible employee to act on the operator's behalf in the absence of the operator. Findings include: - Interview on 04/18/23 at 09:55 AM with "Licensed Nurse" (LN) A, she stated the operator	S3015		

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

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S3015	Continued From page 1 was "out of the building" for the day at a meeting, and she "needed to make some phone calls". LN A stated she was not the interim Director of Nursing, that she was "a floor nurse". At 10:54 LN A confirmed the facility lacked the documentation in writing from the operator designating a responsible employee to act on behalf of the operator when the operator is absent. Interview on 04/19/23 at approximately 05:15 PM with Operator B, she confirmed the facility lacked the documentation in writing designating a responsible employee to act on behalf of the operator when the operator is absent. The operator failed to put in writing authorization of a responsible employee to act on the operator's behalf in the absence of the operator.	S3015		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023024	A. BUILDING: _____ B. WING _____	04/19/2023

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S3028	Continued From page 2	S3028		

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:
K.A.R. 26-41-101 (f) (3) (B) (C)

The facility reported a census of 47 residents. The sample included 3 "Residents'" ((R's) 1, 2 and 3), and 3 closed record reviews (R's 4, 5 and 6). Based on record review and interview the operator neglected to open an investigation to rule out neglect, and report to the department in 24 hours R5's unwitnessed fall that occurred on 02/28/23 at approximately 10:00 AM that resulted in R5's death the night of 03/01/23 from a skull fracture with intercranial bleed that was sustained from that fall.

Findings include:

- Record review for R5 revealed an admission date of 01/14/22 and a discharge date of 02/28/22 with diagnoses of Sjorgen syndrome, essential (primary) hypertension, Non- Hodgkin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023024	A. BUILDING: _____ B. WING _____	04/19/2023

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S3028	Continued From page 3 Lymphoma, presence of cardiac pacemaker, and glaucoma. Review of R5 "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA) dated 02/03/22 identified R5 required physical assistance with bathing, supervision with dressing, she was independent with toileting, transferring, walking/mobility, and eating. She was not marked as using a mobility assistive device. She required supervision with her medications and medical treatments, she was occasionally incontinent of bladder, had impaired short-term memory, and usually was able to make herself understood and she usually understood others. She was marked with falls and impaired vision. Review of R5 combined NSA "Service Plan" dated 01/13/22, identified the following health care services to be provided by the qualified facility staff: ensure R5's skin as kept dry, and assist with toileting, after a fall and before moving R5, evaluate R5 for changes in range of motion and notify the nurse before moving the resident. Staff were to become familiar with R5's daily routine and attempt to anticipate and meet her daily needs. Provide reminders to R5 to use her "cane, walker". Facility licensed nurse or certified medication aide to provide R5's medications. Staff to assist with bathing twice weekly and R5 required staff assistance with toileting. Staff were to report any changes/concerns with transferring to the licensed nurse. Staff to assist with dressing in the morning and evening. R5 "needs reminders to utilize mobility device".	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3028	Continued From page 4 Review of R5 electronic progress notes dated 01/14/22 to 02/28/22 revealed the following notes as the only entries: 01/14/22 at 06:09PM and was a late entry - R5 is a pleasant 96-year-old female, she came from independent living. She would need assistance with toileting, bathing, dressing, and activities of daily living. She used a cane or a walker to ambulate. She was alert and oriented with some confusion. 01/15/22 at 01:13 PM and was a late entry - R5 was doing well, and she was attending meals in the dining room. She was consuming approximately fifty percent of her meals. 01/16/22 at 04:01 PM and was a late entry - R5 was doing well, she did have some complaints with staff and was" verbally aggressive" at times. She was compliant with her medications, and she called for assistance when needed. The record lacked documentation of services provided / instructions for staff to address R5 being verbally aggressive at times, the record further lacked any reasons why R5 was being verbally aggressive. 01/22/22 at 08:05 PM and was a late entry - R5 had a cough and "runny" nose, "over all' not feeling well. Rapid test for COVID-19 was positive. R5 placed in isolation for 10 days. The record lacked any documentation and follow up for actions taken and results of the actions for R5 being isolation for a positive COVID -19 test and not feeling well.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3028	Continued From page 5 02/01/22 10:06 AM and was a late entry - R5 doing well, she continued to have a cough and was out of isolation. 02/02/22 at 12:44 PM R5 continued to refuse to eat even when her food was cut up and made to her preference. "Daughter in law" requested staff to not give supplemental shake as it was causing R5 to have loose stools. The record lacked documentation of actions take and results of actions taken to ensure R5 was having adequate intake. 02/28/22 at 02:49 PM and was a late entry - Resident was seen on camera sitting at the dining room table eating her breakfast, she was wearing her pajamas as she preferred to wear with her walker beside her on the left. She finished her breakfast, got up from the table and walked around to the television area as she normally did, and went to sit in an individual high back chair, she was not lined up with and fell backward. Staff notified me as she was laying on the ground. Vitals were taken and within normal limits. R5 denied pain or distress no bumps or bruising apparent, able to move all extremities, with ease, answered questions appropriately, denied hitting her head and requested assistance in getting up. Staff assisted R5 up and assisted her back to her apartment. "I arrived to the community and assessed R5 and staff reported she had just vomited, her friend arrived and we called the family" to notify them of the fall. "I advised that" R5 should go to the hospital for evaluation due to the vomiting and decreased alertness". Family stated they would	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3028	Continued From page 6	S3028		

transport R5 to the hospital for evaluation. R5 left the facility to go to the hospital at 11:00 AM.

Review of the note dated 02/28/22 and identified as a late entry revealed the note was created on 03/03/22 at 02:50:11 PM and was signed by licensed nurse F. Licensed nurse F was notified by family of R5 death on 03/02/23.

Record review of the intake from the department revealed that licensed nurse F sent in a report on 03/03/22 at 04:18 PM of R5 incident of a fall and that R5 had passed away as a result of the fall.

Licensed nurse F failed to make an electronic progress note of R5's incident of a fall prior to her death as a result of her fall, and she further failed to provide a report of the incident to the department within 24 hours of being notified of R5's unwitnessed fall, and further failed to open an investigation to rule out neglect.

Record review of the facility provided investigation provided to the department and was dated 03/09/22 from Licensed nurse F, revealed that "the kitchen staff heard her fall and responded, and went and got floor staff"

The investigation lacked any signed witness statements from staff present in the building at the time of the unwitnessed fall.

Interview on 04/19/23 at 01:02 PM with kitchen staff G, he confirmed that the R5 had two falls that he was aware of. He stated the first fall he did hear R5 yelling, and he found her approximately 30 feet from where he was in the kitchen over by the activity room doors across

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S3028	Continued From page 7 the fall from the dining room and he did call for help from the floor staff to assist R5. Kitchen staff G continued to state the second fall was not on the same day and the only reason he knew R5 had fallen again is because he saw staff assisting her off of the floor, he continued to state on the second fall he was not involved, and he did not call for assistance from staff. R5 electronic progress notes lacked documentation of two separate falls. Review of the investigation provided by licensed nurse F revealed a signature date of 03/09/22, the incident happened on 02/28/22. The first report sent to the department was dated 03/03/22 which was not within 24 hours of being notified of the incident. The operator neglected to open an investigation to rule out neglect, and report to the department in 24 hours R5's unwitnessed fall that occurred on 02/28/23 at approximately 10:00 AM that resulted in R5's death the night of 03/01/23 from a skull fracture with intercranial bleed that was sustained from that fall.	S3028		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EUDORA	2725 CHURCH ST EUDORA, KS 66025

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S3261	Continued From page 8 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f) (11) The facility reported a census of 47 residents. The sample included 3 "Residents'" ((R's) 1, 2 and 3), and 3 closed record reviews (R's 4, 5 and 6). Based on record review and interview the operator failed to ensure R5's records contained documentation of all incidents, symptoms and other indications of illness or injury, including the dates, times actions taken, and results of the actions taken. Findings include: - Record review for R5 revealed an admission date of 01/14/22 and a discharge date of 02/28/22 with diagnoses of Sjorgen syndrome, essential (primary) hypertension, Non- Hodgkin Lymphoma, presence of cardiac pacemaker, and glaucoma. Review of R5 "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA) dated 02/03/22 identified R5 required physical assistance with bathing, supervision with dressing, she was independent with toileting, transferring, walking/mobility, and eating. She was not marked as using a mobility assistive device. She required supervision with her medications and medical treatments, she was occasionally incontinent of bladder, had impaired short-term memory, and usually was able to make herself understood and she usually understood others. She was marked with falls and impaired vision.	S3261		

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S3261	Continued From page 9	S3261		

Review of R5 combined NSA "Service Plan" dated 01/13/22, identified the following health care services to be provided by the qualified facility staff: ensure R5's skin as kept dry, and assist with toileting, after a fall and before moving R5, evaluate R5 for changes in range of motion and notify the nurse before moving the resident. Staff were to become familiar with R5's daily routine and attempt to anticipate and meet her daily needs. Provide reminders to R5 to use her "cane, walker". Facility licensed nurse or certified medication aide to provide R5's medications. Staff to assist with bathing twice weekly and R5 required staff assistance with toileting. Staff were to report any changes/concerns with transferring to the licensed nurse. Staff to assist with dressing in the morning and evening. R5 "needs reminders to utilize mobility device".

Review of R5 electronic progress notes dated 01/14/22 to 02/28/22 revealed the following notes as the only entries:

01/14/22 at 06:09PM and was a late entry - R5 is a pleasant 96-year-old female, she came from independent living. She would need assistance with toileting, bathing, dressing, and activities of daily living. She used a cane or a walker to ambulate. She was alert and oriented with some confusion.

01/15/22 at 01:13 PM and was a late entry - R5 was doing well, and she was attending meals in the dining room. She was consuming approximately fifty percent of her meals.

01/16/22 at 04:01 PM and was a late entry - R5

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S3261	Continued From page 10	S3261		

was doing well, she did have some complaints with staff and was" verbally aggressive" at times. She was compliant with her medications, and she called for assistance when needed.

The record lacked documentation of services provided / instructions for staff to address R5 being verbally aggressive at times, the record further lacked any reasons why R5 was being verbally aggressive.

01/22/22 at 08:05 PM and was a late entry - R5 had a cough and "runny" nose, "over all' not feeling well. Rapid test for COVID-19 was positive. R5 placed in isolation for 10 days.

The record lacked any documentation and follow up for actions taken and results of the actions for R5 being isolation for a positive COVID -19 test and not feeling well.

02/01/22 10:06 AM and was a late entry - R5 doing well, she continued to have a cough and was out of isolation.

02/02/22 at 12:44 PM R5 continued to refuse to eat even when her food was cut up and made to her preference. "Daughter in law" requested staff to not give supplemental shake as it was causing R5 to have loose stools.

The record lacked documentation of actions take and results of actions taken to ensure R5 was having adequate intake.

02/28/22 at 02:49 PM and was a late entry - Resident was seen on camera sitting at the dining room table eating her breakfast, she was

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S3261	Continued From page 11	S3261		

wearing her pajamas as she preferred to wear with her walker beside her on the left. She finished her breakfast, got up from the table and walked around to the television area as she normally did, and went to sit in an individual high back chair, she was not lined up with and fell backward. Staff notified me as she was laying on the ground. Vitals were taken and within normal limits. R5 denied pain or distress no bumps or bruising apparent, able to move all extremities, with ease, answered questions appropriately, denied hitting her head and requested assistance in getting up. Staff assisted R5 up and assisted her back to her apartment. "I arrived to the community and assessed R5 and staff reported she had just vomited, her friend arrived and we called the family" to notify them of the fall. "I advised that" R5 should go to the hospital for evaluation due to the vomiting and decreased alertness". Family stated they would transport R5 to the hospital for evaluation. R5 left the facility to go to the hospital at 11:00 AM.

Review of the note dated 02/28/22 and identified as a late entry revealed the note was created on 03/03/22 at 02:50:11 PM and was signed by licensed nurse F. Licensed nurse F was notified by family of R5 death on 03/02/23.

Record review of the intake from the department revealed that licensed nurse F sent in a report on 03/03/22 at 04:18 PM of R5 incident of a fall and that R5 had passed away as a result of the fall.

Licensed nurse F failed to make an electronic progress note of R5's incident of a fall prior to her death as a result of her fall.

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S3261	Continued From page 12 Record review of the facility provided investigation provided to the department and was dated 03/09/22 from Licensed nurse F, revealed that "the kitchen staff heard her fall and responded, and went and got floor staff" Interview on 04/19/23 at 01:02 PM with kitchen staff G, he confirmed that the R5 had two falls that he was aware of. He stated the first fall he did hear R5 yelling, and he found her approximately 30 feet from where he was in the kitchen over by the activity room doors across the fall from the dining room and he did call for help from the floor staff to assist R5. Kitchen staff G continued to state the second fall was not on the same day and the only reason he knew R5 had fallen again is because he saw staff assisting her off of the floor, he continued to state on the second fall he was not involved, and he did not call for assistance from staff. R5 electronic progress notes lacked documentation of two separate falls. The operator failed to ensure R5's records contained documentation of all incidents, symptoms and other indications of illness or injury, including the dates, times actions taken, and results of the actions taken.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency	S3280		

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S3280	Continued From page 13	S3280		

management plan;
(2) education of each resident upon admission to the facility regarding emergency procedures;
(3) quarterly review of the facility ' s emergency management plan with employees and residents; and
(4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.

This REQUIREMENT is not met as evidenced by:
K.A.R. 26-41-104 (d)(3)

The facility reported a census of 47 residents. Based on record review and interview the operator failed to ensure the quarterly training of the facility's emergency management plan was reviewed at least quarterly with all staff and all residents.

Findings include:

- Review of the facility emergency management plan quarterly reviews with employees revealed the following training dates: 02/01/23, 01/24/22, and 10/25/22. Review of the quarterly emergency management plan quarterly review for residents revealed the only training date was 04/04/22.

Interview on 04/19/23 at 05:15 pm with Operator B and Regional "Licensed Nurse" (LN) D, they confirmed the last survey date was 07/28/21, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023024	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EUDORA	2725 CHURCH ST EUDORA, KS 66025

(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
S3280	Continued From page 14 they continued to confirm the facility lacked documentation of emergency quarterly preparedness training for staff and residents at least quarterly since the last survey. The operator failed to ensure the quarterly training of the facility's emergency management plan was reviewed at least quarterly with all staff and all residents.	S3280		
S3310 SS=D	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: K.A.R. 26-41-207 (c) The facility reported a census of 47 residents, and 5 newly hired employees. Based on record review and interview the operator failed to ensure the facility's compliance with the	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3310	Continued From page 15 departments "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired employee C. Findings include: - Record review for newly hired employee C revealed she began employment on 12/31/22. The employee record lacked the required 2 step TB test within 7 days of employment. Interview on 04/19/23 with Operator B, she confirmed the employee record lacked the documentation of the required 2 step TB test within 7 days of employment. The operator failed to ensure the facility's compliance with the departments "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired employee C.	S3310		