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 _____	06/27/2023

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

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S 000	INITIAL COMMENTS The following citation represents the findings of an abbreviated survey for complaint #181073 at the above named facility conducted on 06/27/23.	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 53 residents. The sample included 1 closed record review resident. Based on record review and interview for cognitively impaired Resident (R)1, Administrator A failed to ensure no resident was subjected to neglect when staff failed to ensure the bed assistive device was assessed for appropriate fit and size, failed to ensure the bed assistive device was securely attached per manufacturers recommendations and standards of practice when staff utilized zip ties to secure the bed assistive device to R1's bed, and failed to ensure adequate staff supervision for R1 who had not slept in his bed consistently prior to this night. On 06/24/23, R1 became lodged between	S3026		

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

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the bed assistive device and the bed, and subsequently died. These failures placed R1 in immediate jeopardy along with 7 other residents who used bed assistive devices at risk.

Findings included:

- R1's medical record revealed he admitted to the facility on 10/18/22 with diagnoses of dementia, insomnia, disorder of bone, bipolar disorder, major depressive disorder, hypertension, hyperlipidemia and diabetes mellitus type II.

The "Functional Capacity Screen/ Negotiated Service Agreement" (FCS/NSA) dated 06/03/23 recorded the resident required physical assistance with bathing, toileting, transfer, walking/mobility and was unable to perform dressing and management of medications and treatments. The FCS/NSA recorded R1 had impaired short term memory, impaired memory/recall and impaired decision making. The FCS/NSA further recorded R1 was frequently incontinent of urine, was at risk for falls and unsteadiness and had impaired vision. R1 used a walker and wheelchair for mobility. The FCS/NSA failed to identify a bed assistive device used for transfers and frequency of any visual checks to be completed. The FCS/NSA was signed by Licensed Nurse (LN) B, dated 06/03/23. The FCS/NSA was not signed by R1 or any legal representative or family member .

The "Service Plan" updated 06/15/23 recorded facility staff assisted R1 with bathing and dressing, one person assistance needed for toileting, physical assistance needed for

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transfers, one-to-two-person moderate assistance with gait belt required for mobility, required reminders for meals and staff administered medications. The "Service Plan" recorded staff to assist R1 to change positions every 2 hours due to risk for skin breakdown and further recorded R1 used a bed cane for mobility and safety. Fall intervention recorded and initiated on 06/15/23 by LN B recorded staff to walk resident as much as tolerated before bed. The "Service Plan" failed to identify interventions to address R1's impaired short-term memory, memory/recall impairment and impaired decision making. The "Service Plan" lacked signatures from facility licensed nurse, R1 or any legal representative or family member.

Review of R1's medical record revealed hospital stay from 05/26/23 to 06/03/23 with diagnoses of Sepsis (life threatening complication to infection), cellulitis (bacterial skin infection) and altered mental status. R1's medical record further revealed 5 falls from 06/08/23 to 06/16/23, all of which occurred in R1's apartment.

The "Assisted Living Bed Mobility Device" assessment dated 11/22/22 recorded R1's bed device was used for turning and re-positioning, getting in and out of bed, movement in bed and defined the edges of the bed. The assessment recorded the bed device type as a bed cane used on a hospital bed, secured by straps, device fit and was appropriate for style of bed used and mattress fit tightly against the bed device on both sides of the bed. The assessment recorded the bed device was to be checked weekly for safety and compliance in TELS (web-based software) and a managed risk

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agreement was in place. The "Assisted Living Bed Mobility Device" was signed by LN C and dated 12/29/22.

R1's medical record revealed no bed mobility device assessment completed by a licensed nurse since 11/22/22.

The "Managed Risk Agreement" dated 12/13/22 recorded R1 chose to utilize the bed cane after consideration of possible injury, entrapment and/or death. The "Assisted Living Bed Mobility Device" was signed by LN C and dated 12/13/22. The agreement lacked signatures from R1 or any legal representative or family member.

"Progress Notes" dated 12/13/22 by LN C recorded, "[R1] utilizes bed cane for bed mobility and transfers. At this time [R1] wishes to continue to utilize the bed cane. Bed cane will be checked weekly for compliance and safety."

Record lacked evidence of completion of weekly bed cane checks for compliance and safety.

Certified Nurse Aide (CNA) F's signed statement dated 06/26/23 recorded, "[R1] slept in his bed because his recliner had been taken out. Previously he slept occasionally in his recliner. He was a check and change. [R1] used a broda chair, he had been trying to get up and walk (he had 3 previous falls in the past 2 weeks). On 06/23/23, I do not know what time [R1] was put to bed, he was already in bed when my shift started at 11:00 PM. We do rounds on all memory care residents. Not all are a check and change but every 2 hours we put eyes on them. [R1] was

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care planned to be checked every 2 hours. When I came in at 11:00 PM I like to see each resident for myself. Rounds are done at 12:00 AM, 02:00 AM, 04:00 AM and 06:00 AM. On 06/23/23 into 06/24/23, I looked in on all residents between 11:00 PM and 11:40 PM. [R1] was in his bed. At 02:04 AM, we started our rounds and we got to [R1's] room at approximately 02:10 AM. When I walked in I did not see [R1] in the bed, as I got all the way in he was off of the bed and his neck was on the bed rail between the rail and mattress wedged in. Because of his body weight we could not lift him off of the rail. [CMA H] had to bend the rail backwards (it was attached to bed) and I lifted his mattress, so [CNA G] could pull his head out."

Certified Nurse Aide (CNA) G's signed statement dated 06/27/23 recorded, "Yes, resident used Broda (specialized chair for positioning) chair for lack of mobility. When [R1] returned on 06/03/23 he was not the same as when he left. I came in at about 10:30 PM [06/23/23]. My coworker checked on residents between 11:40 PM - 12:00 AM. I saw the resident around 02:10 AM- 02:15 AM while doing first rounds. This time was the first time I saw the resident during this shift. I was not the person(s) who put [R1] to bed on 06/23/23. 12:00 AM, 02:00 AM, 04:00 AM, 06:00 AM- round times to be completed on all residents. [R1] was check and change, 2 people [person assist], incontinent, did not use toilet. After 06/03/23 he started to decline and could not make it to the toilet. Unable to get his head out because it was caught between the bed rail and the bed. Head was towards the head of the bed stuck between the bed rail and the mattress. His bottom was on the ground and his legs were

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in a bent position to the side. His face was pale white and his legs had purple veins that had pools of purple on them from being in the sitting position. I was told by evening shift that client was put in his bed around 11:00 PM. From 11:40 PM - 12:00 AM my coworker checked the residents. The client usually preferred the chair but would occasionally sleep in the bed. The client would try to get out of bed without using the call light most times. The client made a comment that it did not matter where he was he was going to try to get up on his own."

Interview on 06/27/23 at 02:30 PM with LN C confirmed bed mobility device assessment last completed 11/22/22 and further confirmed the "FCS/NSA" dated 06/03/23 failed to identify a bed assistive device used for transfer.

Interview on 06/27/23 at 02:37 PM with Administrative Staff B confirmed measurements of zones on bed assistive device were not included in the "Assisted Living Bed Mobility Device" assessment.

Interview on 06/27/23 at 02:40 PM with Administrative Staff B and LN C confirmed "Managed Risk Agreement" dated 12/13/22 lacked signatures of R1 or any legal representative or family member.

Interview on 06/27/23 at 04:46 PM with Administrative Staff B confirmed R1's bed assistive device was secured to hospital bed with zip ties.

Electronic interview on 06/28/23 at 04:07 PM with Maintenance Supervisor I revealed

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instructions to be completed by his company weekly, which recorded, "inspect all beds for full function, inspect mattresses if mattress is torn, peeling or damaged replace cover or mattress. Inspect for any gaps larger than 4 ¾ inches, if a gap is larger than 4 ¾ inches, the gap needs to be corrected. Inspect transfer device "rails." Inspect connectors on rails and tighten as necessary. Remove any burs or rough edges to prevent injury. Also inspect cranks if applicable. Check for missing or faulty screws. Items identified as poor condition should be removed from service."

Electronic interview on 06/28/23 at 06:06 PM with Maintenance Supervisor I confirmed specific resident reports were not recorded.

Electronic interview on 06/29/23 at 02:01 PM with LN C stated weekly checks for bed assistive devices are not a procedure or policy of the operator.

Electronic interview on 06/29/23 at 03:43 PM with Administrative Staff B confirmed unable to provide manufacturer of the bed assistive device used by R1 with installation instructions.

R1's bed and bed assistive device was taken out of the facility on 06/24/23 .
Facility's "Side Rail Utilization" policy (no date) recorded, "it is the policy of the facility to ensure the safety and well-being of all residents. The use of side rails in the facility is prohibited. 1.) the use of a bed cane, transfer pole, trapeze, or other approved adaptive equipment may be utilized to aid the resident with repositioning/transfers. Once it is determined

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S3026	Continued From page 7 that a transfer/ repositioning device should be utilized, the usage of the transfer/repositioning device must by included in the NSA/Health Service Plan under "transfers."" Facility failed to provide a policy on managed risk agreements. Operator A failed to ensure no resident was subjected to neglect when staff failed to ensure the bed assistive device was assessed for appropriate fit and size, failed to ensure the bed assistive device was securely attached per manufacturers recommendations and standards of practice when staff utilized zip ties to secure the bed assistive device to R1's bed, and failed to ensure adequate staff supervision for R1 who had not slept in his bed for a long time prior to this night. On 06/24/23, R1's head became lodged between the bed assistive device and the bed, and subsequently died. These failures placed R1 in immediate jeopardy and 7 other residents who used bed assistive devices at risk. The immediate jeopardy was removed on 06/24/23 when R1 died and facility staff removed bed assistance devices from the facility. Abatement plan obtained on 06/27/23 at 01:18 PM when LN C stated all bed assistive devices were removed from residents' beds on 06/24/23 except one resident, who signed a managed risk agreement for her bed assistive device.	S3026		