STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089033	A. BUILDING: _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEGGY KELLY HOUSE I	2111 SW RANDOLPH AVENUE TOPEKA, KS 66614

(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 are the result of an abbreviated survey with complaint #63235 conducted on 6/23/21 and 6/24/21 at the above named home plus facility in Topeka, KS.	S 000		
S5171 SS=D	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (i) The facility reported a census of 10 residents. The sample included 3 residents. Based on record review, observation and interview for 1 sampled resident (#2) the operator failed to ensure all health care services were provided to the resident in accordance with acceptable standards of practice. Findings included: - Record review for resident #2 recorded admission date of 7/17/20 with diagnoses of: traumatic subdural hemorrhage, dysphasia, dysarthria, arteriosclerotic heart disease, depression, hypertension and benign prostatic hypertrophy. Functional Capacity Screen (FCS) dated 1/13/21 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility, eating and unable to perform management of medications and treatments.	S5171		

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

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S5171	Continued From page 1	S5171		

Resident has problems with short term memory, memory recall and decision making and has a history of falls/unsteadiness.

Negotiated service agreement/ health care service plan (NSA/HCSP) dated 1/13/21 recorded staff and/or hospice to provide physical assistance with bathing, staff to provide physical assistance with dressing, toileting, transfer (1 assist with a sit-stand lift), walk/mobility and eating.

Progress notes (nurses notes) recorded entries on 6/10/21 at 1:19pm: "Trazadone 25mg (milligrams) (anti-depressant) discontinued due to resident already on 50 mg at hs (bedtime) ....." signed by licensed nurse #B.

Next entry is 6/13/21 at 12:45 pm: "PRN (as needed) administration was effective." Signed by certified staff #E.

Entries in facility staff communication books recorded the following:

6/10/21 11-7 shift: [resident #2] rolled out of bed early this morning, didn't get hurt, called [nurse #B] she told me what to do."

6/11/21 7-3 shift recorded: [resident #2] "helped get him up off floor, put him in his recliner went back to sleep.
Notarized statement from certified staff #C recorded she changed the resident about 5am, around 5:10am she heard a noise in his room, went to check on him and he had rolled out of bed and onto a fall mat and body pillow. She asked if he was ok and if he wa in any pain, he said he was fine. She tried to help him up, was not able to so she called licensed nurse #B ....

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S5171	Continued From page 2 she told her to make him comfortable and wait for the morning person to come in and help me get him up. She went in and made sure he was comfortable, put a blanket over him. Certified staff #D came in about 6:30am and they got him up. Observation on 6/23/21 at 3:00pm in resident's room revealed a twin bed with low air flow mattress with bolsters in place, bed in low position at approximately 19 inches off the floor, a blue fall mat by the wall at the head of the bed measured 2 inches of cushion. Interview on 6/23/21 at 2:27pm with licensed nurse #B confirmed on the morning of 6/11/21 she was called at 5:27am and told he rolled out of bed but was not hurt, she did not come in and assess the resident in person, she told the staff member to make him comfortable until the next shift arrived and get him up. She called back in at 7:50am to check on him and staff stated he was fine. She confirmed she did not do any documentation of the incident, she did not notify the doctor, family or hospice at the time of the incident. For resident #2 the operator failed to ensure all health care services were provided to the resident in accordance with acceptable standards of practice when the licensed nurse failed to assess the resident after a fall allowing the resident to remain on a fall mat for over an hour, failed to notify the physician, family and hospice at the time of the fall, and failed to document the fall and condition post fall in the resident record.	S5171		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents	S5251		

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S5251	Continued From page 3 (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. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The facility reported a census of 10 residents. The sample included 3 residents. Based on record review and interview for 1 sampled resident (#2), the operator failed to ensure documentation on residents in accordance with accepted professional standards and practices including all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #2 recorded admission date of 7/17/20 with diagnoses of: traumatic subdural hemorrhage, dysphasia, dysarthria, arteriosclerotic heart disease, depression, hypertension and benign prostatic hypertrophy. Functional Capacity Screen (FCS) dated 1/13/21 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility, eating and unable to perform management of medications and treatments.	S5251		

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S5251	Continued From page 4	S5251		

Resident has problems with short term memory, memory recall and decision making and has a history of falls/unsteadiness.

Negotiated service agreement/ health care service plan (NSA/HCSP) dated 1/13/21 recorded staff and/or hospice to provide physical assistance with bathing, staff to provide physical assistance with dressing, toileting, transfer (1 assist with a sit-stand lift), walk/mobility and eating.

Progress notes (nurses notes) recorded entries on 6/10/21 at 1:19pm: "Trazadone 25mg (milligrams) (anti-depressant) discontinued due to resident already on 50 mg at hs (bedtime) ....." signed by licensed nurse #B.

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Entries in facility staff communication books recorded the following:

6/10/21 11-7 shift: [resident #2] rolled out of bed early this morning, didn't get hurt, called [nurse #B] she told me what to do."

6/11/21 7-3 shift recorded: [resident #2] "helped get him up off floor, put him in his recliner went back to sleep ..."

Written statements from certified staff #B, C and D, confirmed resident rolled out of bed the morning of June 11th.

Resident record lacked documentation of the incident, notification of physician and family, assessment for potential injuries and follow up

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S5251	Continued From page 5 monitoring after the incident. Interview on 6/23/21 at 2:27pm with licensed nurse #B confirmed resident rolled out of bed on 6/11/21 and resident record lacked documentation of the incident she confirmed family and physician were not notified of the incident. For resident #2 the operator failed to ensure documentation on resident in accordance with accepted professional standards and practices including all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the action.	S5251		