STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089063	A. BUILDING: _____ B. WING _____	09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA HEARTHSTONE EAST	3415 SW 6TH AVENUE TOPEKA, KS 66606

(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 a resurvey with a complaint #168364, 166835 and 171018 at the above named Assisted Living, conducted on 09/07/22, 09/08/22 and 09/12/22.	S 000		
S3155 SS=E	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: 3155 KAR 26-41-204(a) The facility reported a census of 84 residents. The sample included six residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for two of six sampled residents evidenced by the failure to complete and document an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for Resident (R)103, and R105. Findings included:	S3155		

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

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S3155	Continued From page 1 - R103's medical record revealed the resident moved into the facility on 12/02/21 with a diagnosis of skin cancer. The 12/29/21 "Functional Capacity Screen" (FCS) documented R103 was independent with transfers, walking/mobility and did not use an assistive device. The 12/29/22 "Resident Functional Needs Assessment" documented R103 was independent with transfers and walking and did not use an assistive device. Review of R103's medical records failed to locate an assessment for the use of a bed cane. An observation on 09/12/22 at 01:38 PM revealed there was a bed cane attached on the left side of R103's bed. This bed cane was not attached properly and could be easily pulled away from the bed. On 09/12/22 at 01:38 PM R103 stated he was able to transfer on his own and walked independently without a walker. R103 stated his family purchased a bed cane to help prevent him from falling out of his bed when he was asleep. On 09/12/22 at 01:09 PM Certified Medication Aide (CMA) C stated R103 transferred and walked independently and did not use a walker. CMA C stated she thought R103 had bed canes attached to both sides of his bed but did not know if he has had any falls. On 09/12/22 at 01:50 PM Licensed Nurse (LN) D stated R103 was able to transfer and ambulate independently without any assistive devices. LN	S3155		

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S3155	Continued From page 2 D stated R103 had a bed cane attached to his bed and he had fallen two times, both when he fell out of his bed. LN D stated maintenance staff moved the bed cane to the left side of the bed as a fall intervention. On 09/12/22 at 02:25 PM LN B stated she had not completed a bed rail assessment for R103. A policy concerning bed rail assessments was requested on 09/12/22 but Administrative Staff A stated he could not find one. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R103 regarding the use of a bed assistive device. - Resident (R)105s medical record revealed the resident moved into the facility on 01/24/20 with a diagnosis of Alzheimer's Disease. The 07/20/22 "Functional Capacity Screen" (FCS) documented R105 was independent with transfers and mobility and listed the use of a walker. The 07/20/22 "Resident Functional Needs Assessment" documented R105 independently ambulated with a walker, transferred independently using a "UBAR." Review of R105's medical records failed to locate an assessment for the use of a bed cane. An observation on 09/12/22 at 01:27 PM revealed a bed cane was properly installed on the left side of R105's bed.	S3155		

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S3155	Continued From page 3 On 09/12/22 at 01:27 PM R105 stated she used the bed rail to help her get out of her bed. On 09/12/22 at 01:13 PM Certified Medication Aide (CMA) C stated the R103 had a bed cane attached to her bed. On 09/12/22 at 01:56 PM Licensed Nurse (LN) D stated R105 used a bed cane but was not aware of bed rail assessments being completed prior to their use. On 09/12/22 at 02:25 PM LN B stated she did not utilize an actual bed rail assessment form but interviewed R105. LN B stated she did not document the assessment anywhere but listed the use of a bed cane on the "Resident Functional Needs Assessment" under the heading of assistive/adaptive devices. A policy concerning bed rail assessments was requested on 09/12/22 but Administrative Staff A stated he could not find one. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R105 regarding the use of a bed assistive device.	S3155		
S3171 SS=D	26-41-204 (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.	S3171		

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S3171	Continued From page 4 This REQUIREMENT is not met as evidenced by: 3171 26-41-204(i) The facility reported a census of 84 residents. The sample included six residents. Based on interview and record review the operator failed to ensure designated staff provided the necessary health care services to meet the needs for one of six sampled residents evidenced by the failure of facility staff to complete scheduled resident status checks on Resident (R)102 who ended up lying on the floor of his apartment for approximately three and a half hours after experiencing a fall. Findings included: - R102's medical record revealed the resident moved into the facility on 12/16/21 with a diagnosis of dementia. The 12/16/21 "Functional Capacity Screen" (FCS) documented R102 was independent with transfers, walking/mobility and used a walker. The 12/15/22 "Resident Functional Needs Assessment" documented R102 was independent with transfers and walking and triggered for falls and impaired decision-making. Staff were to complete resident status checks due to R102's recent move into the facility and medication changes. The 12/15/22 "Resident Function Needs Service Plan" documented staff were to observe R102's condition once per shift. The January 2022 "Resident Monthly Assignment Report" documented Certified Nurse Aide (CNA)	S3171		

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S3171	Continued From page 5 E charted status checks on R102 at 02:00 AM and 04:00 AM. The 01/03/22 "Incident Note" documented R102's family called the concierge at approximately 06:00 AM to report that they noticed via camera that R102 was on the floor in his apartment. The 01/03/22 "General Note" by Administrative Staff A documented he spoke with R102's family regarding his fall. Family reported while reviewing camera footage they were able to see R102 was on the floor in his apartment at 02:30 AM. On 09/08/22 at 02:14 PM Licensed Nurse (LN) F stated R102 had a fall in his apartment and the facility was notified by his family that they saw him on the floor after they reviewed video footage from a camera located in his room. On 09/08/22 at 02:26 PM Administrative Staff A reported an employee falsely documented resident status checks for R102 two times on 01/03/22. On 09/12/22 at 04:20 PM Administrative Staff A stated staff were to check all residents who lived in the "Life Guidance" unit twice during the night shift at 02:00 AM and 04:00 AM. Administrative Staff A stated he expected staff to completed status checks twice a night and that CNA E falsely documented completion of these resident status checks. The operator failed to ensure designated staff completed resident status checks for R102 who was on the floor of his apartment for approximately three and a half hours after falling.	S3171		