STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175541	A. BUILDING _____ B. WING _____	C 07/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLGRASS CREEK, INC	13760 METCALF AVENUE OVERLAND PARK, KS 66223

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F 000	INITIAL COMMENTS	F 000		

A complaint survey #KS00143800 and #KS00143802 was conducted by the Kansas Department of Aging and Disability services (KDADS) on behalf of the Centers for Medicare and Medicaid Services (CMS) on 7/29/19.

On 7/29/19 at 05:30 PM, the Director of Nursing (DON) was provided with the "Immediate Jeopardy Template". The facility was notified that the failure to ensure residents were not served food items to which the residents had a documented food allergy constituted an immediate jeopardy at F806 to all residents with documented food allergies.

The immediate jeopardy was determined to first exist on 7/22/19 between 05:00 PM and 06:00 PM when Resident (R)1 was served a salad which contained almonds. R1 had a documented food allergy to almonds. The salad, which was not supposed to contain almonds, was incorrectly prepared and served by the dietary department. R1 consumed the salad and developed symptoms of a moderate to severe allergic reaction. R1 required emergent transport and treatment at an acute care facility to reverse the potentially life-threatening reaction.

The facility presented an acceptable plan for removal of the immediate jeopardy on 7/29/19 at 05:35 PM. The survey team validated that the immediate jeopardy was removed on 7/29/19 at or around 05:40 PM following the facility's implementation of the plan for removal of the immediate jeopardy.

The deficient practice remained at a "G" (isolated

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/22/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 with actual harm) scope and severity following the removal of the immediate jeopardy. The 2567 was sent electronically sent to the provider on 08/14/19. A revised 2567 was sent electronically to the provider on 9.17.19	F 000		
F 806 SS=K	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included three residents with food allergies. Based on record review, observation and interviews, the facility failed to serve food that accommodated a resident's allergies (a damaging immune response by the body to a substance, like a particular food, to which it has become hypersensitive), when one of four residents (R)1, identified with food allergies was served almonds in his salad. On 7/22/19 at approximately 05:00 to 06:00 PM R1 unknowingly consumed almonds which were mistakenly added to the salad by dietary staff. R1 suffered anaphylaxis (a serious, life-threatening allergic reaction) and required emergency	F 806		

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F 806	Continued From page 2	F 806		

medical services at an acute care hospital to reverse the severe allergic reaction. This placed R1 and four residents (identified with food allergies) in immediate jeopardy.

Findings included:

- R1's "Electronic Medical Record" (EMR) recorded he admitted to the facility in 2018 with multiple medical problems including: hypertension (HTN- a long-term medical condition in which the blood pressure in the arteries is persistently elevated) and multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord).

R1's "Significant Change" minimum data set (MDS) assessment dated 05/27/19 documented a Brief Interview for Mental Status (BIMS) Score of 15 which indicated intact cognition. The MDS documented the resident required extensive assistance of one to two staff with most activities of daily living (ADL's) and fed himself a regular diet.

The 05/27/19 nutritional "Care Area Assessment" (CAA) documented R1 was at risk for nutritional problems due to his medical conditions and staff would develop a care plan to address concerns.

Review of the residents profile (Face sheet) in the EMR, documented R1 had an almond allergy.

Review of the resident's care plan dated 03/2019 and revised 07/24/19 documented R1's allergy to almonds.

Review of the nurses progress notes in the EMR

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recorded on 07/22/19 at 06:10 PM, Licensed Nurse (LN) H heard R1 call for help. R1 verbalized he felt he was having a reaction to a salad he just ate. LN H called the kitchen to confirm ingredients of the salad and kitchen personnel came and spoke with the resident. A few minutes later R1 made the decision to transfer to the emergency room and R1 called emergency medical services (EMS).

The nurses progress notes recorded R1 returned from the hospital on 07/22/19 at 10:20 PM with stable vital signs and a physician's order for Prednisone (an anti-inflammatory and immune system suppressant medication) 60 milligrams by mouth daily for 4 days.

Review of the facility's investigation and hospital records revealed R1 suffered a moderate to severe anaphylactic reaction.

At the hospital, RI received intramuscular injections of Benadryl, and Famotidine, medications that block the release of Histamine (an immune response chemical substance and neurotransmitter to the brain), and Prednisone (a synthetic drug similar to cortisone, used to relieve rheumatic and allergic conditions).

The facility investigation concluded: on 07/22/19 a line cook dietary cook, (DC) CC brought it to the attention of Assistant Dietary Manager (ADM) BB that a carrot salad was made incorrectly and contained almonds when those were not called for in the recipe, nor listed on the ingredients menu. The information was communicated by a written note left on ADM BB's computer as well as through a phone call from the cook (DC) DD who made the salad incorrectly. DC DD also left a

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note on the container the salad was in, warning staff the salad contained almonds. This information was not passed along to the cooks working on that day or to the staff serving in the units. "A resident in Post- Acute was allergic to almonds and consumed the salad resulting in him being taken to the emergency room." After the incident ADM BB admitted she was aware the salad contained the nuts, but stated she forgot because the note got buried in a pile of papers on her desk.

Observation on 07/29/19 at 11:50 AM revealed R1 sat in the dining room alert and talking with tablemates.

Interviewed on 07/29/19 at 3:18 PM R1 stated he knew he consumed almonds by the taste. He was allergic to them for about 80 years and about 20 years ago had a severe anaphylactic reaction to them. "When I know I have had almonds they give me a cocktail of medicines in the emergency room. When I got back, they told me there were almonds in the salad. Before that happened, nobody knew that, but I felt uncomfortable so I'm glad I went." R1 stated he called 911 because they (facility staff) were under the impression there were not almonds in the salad. Dining Services Manager (DSM) AA told R1 they have taken three steps) to prevent that happening again.

Per Dietary Cook (DC) CC's notarized witness statement dated 07/29/19 around 6:05 PM recorded he received a call from LN H. He could not understand what she was saying as she was talking very fast and he could not understand her accent. He then stated he hung up the phone and decided to walk down to see LN H in person.

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When he arrived, he was asked by LN H if the carrot salad contained almonds. He had a menu with him, and the recipe did not state it had almonds. He then went to look at the salad and stated he thought the ingredients looked like carrots, mayonnaise, grapes, and ginger (not almonds). DC CC then went back to the kitchen where he communicated to ADM BB the situation. ADM BB stated she remembered and they both went down to tell the LN H it contained almonds.

Per ADM BB's notarized witness statement dated 07/29/19: Over the weekend DC DD mixed up the salad recipes and put almonds into the wrong salad. He labeled the salad container stating that it contained almonds. ADM BB also stated that DC DD notified her and left a sticky note in the office regarding the mix up. During the day on July 22nd the servers split up the salad. Moving the salad from the big container to a smaller container to go to each dining room. ADM BB stated the servers must not have seen the note on the container. The salad then went out and was served. ADM BB also confirmed that she did not change the menu or nutritional guides to reflect the addition of almonds. ADM BB remembered after the meal the salad had almonds when DC CC came to tell her that a situation was occurring and asked if the salad contained almonds. ADM BB then went to tell the LN H the salad did contain almonds.

Interviewed on 07/29/19 at 12:26 A.M. Administrative Nurse D stated the dietary sheets, specific to residents' diet, were kept in serving area and serving staff referred to it when serving food. In this instance the recipe was not followed, and the online menu and paper menu were not updated to reflect the addition of almonds. ADM

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BB was aware and did not take any action with the addition of almonds and DC DD did not follow the prescribed menu.

Interviewed on 07/29/19 at 12:28 PM Dining Services Manager (DSM) AA stated he interviewed DC DD regarding the incident. DC DD had almonds out, that he had toasted for the next day recipe, and the moment he put them in the salad, he knew what he had errored. He called the ADM BB at home and she did not answer so he put a note on her desk and sent an email. When asked why he did not throw it out, he stated because facility did not have any more carrots DSM AA stated this had not happened before, we have given wrong diet before, but no allergies food to any resident. Staff are trained on following the menu; the problem was that DC DD did not throw it out. We are going to make things that are not correct at times, but the key is to throw it out. and do it over.

The facility's "Resident Diet List" policy dated 6/2012 recorded each dining room will have computer screen display (Cbord) menu at the serving areas with all resident room numbers, diet order, allergies, preferences/dislikes for resident of the neighborhood/household.

The facility's "Food Preparation and Service" policy dated 05/2012 recorded strict food preparations procedures were maintained to assure consistent high-quality food service.

The facility's "Standardized Recipes" policy dated 06/2012 recorded Standardized recipes will be written and used for all meals prepared in the continuing care residence.

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The facility's "Net-Menu-Recipe Additions and Changes" policy dated 10/8/2018 recorded Clarification of the reason for any recipe changes must be outlined.

The facility failed to ensure R1, with a documented almond allergy, was not served almonds which resulted in a potentially life-threatening reaction and the need for emergency medical treatment.

The facility removed the immediate jeopardy on (date/time)by completing the following:
An audit was completed for residents residing in Post-Acute and Long-Term Care to ensure all allergies were accurately documented in the resident medical record. The Dining Manager conducted daily audits beginning on July 23, 2019 to verify that recipes were accurately followed. Dining staff were educated on the importance of following Erickson approved dining polices to ensure accurate production of meals according to recipe and delivery of correct meals to resident with food allergies. The Dining Service's Daily Operation Book includes a daily form to document recipe compliance. The Dining Manager will acknowledge that the recipes were followed as written and will sign the Operations book daily acknowledging that food was prepared as directed. Any food item not prepared according to the recipe will be discarded prior to serving. Each new hire will be educated on policies listed above, along with the new process to validate recipes have been followed. Dining Director and/or designee will complete daily audits to verify food was prepared according to recipe instructions and document audit findings in Erickson approved form. Audits will be completed daily for 1 month then weekly for 1

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F 806	Continued From page 8 month and then every other week for the next 2 months. Results of audits will be reviewed with NHA weekly and at monthly QAPI committee meeting. The deficient practice remains at a scope and severity of a G.	F 806		