

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/21/2022
NAME OF PROVIDER OR SUPPLIER CEDAR LAKE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 15325 S LONE ELM RD OLATHE, KS 66061		
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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with complaint numbers 171588 and 169823 attached, for the above named facility conducted on 7/18/2022, 7/19/2022, 7/20/2022, and 7/21/2022.	S 000		
S3026 SS=G	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 26-42-101 (f) ((1) (B) The facility reported a census of 56 residents. The sample included 3 residents (R) and one closed record review. Based on record review and interview the administrator failed to ensure the licensed nurse placed interventions for R 111 who had multiple falls. This failure of interventions allowed R 111 to continue to fall with one resulting in the dislocation of the right hip and a facial laceration. The administrator further failed to acknowledge a change in cognition/decision making for R 115 which resulted in the resident leaving the facility without staff knowledge in 18-degree Fahrenheit weather wearing only a red jacket, having an unwitnessed fall resulting in an emergency room visit to assess a facial injury.	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	Continued From page 1 Findings included: - Record review for R 111 on 07/20/22 revealed an admission date of 03/21/22 with diagnoses of right hip dislocation, falls, weakness, history of cerebral vascular accident, hypertension, atrial fibrillation, dementia without behaviors, chronic kidney disease, osteo arthritis, chronic pain and major depressive disorder. Record review of the "Functional Capacity Screen" FCS dated 03/09/22 identified R 111 required physical assistance with bathing and dressing. She required supervision with toileting and lacked the ability to manage her own medications. The resident had impaired short-term memory, long term memory, memory/recall and decision making. She was usually understandable and understood others. She was marked at risk for falls/unsteadiness and used a walker or wheelchair for mobility. Record review of the unsigned combined "Negotiated Service Agreement "(NSA)"/"Healthcare Service Plan" (HSP) dated 03/21/22 identified the following healthcare services/instructions provided by the facility; R 111 was alert to person, independent with mobility with a walker for short distances and a wheelchair for long distances, toileting and transfers. She required one person assist with grooming, dressing/undressing, and bathing. Under the heading of falls there is a handwritten noted dated 04/19/22 which stated staff were to encourage resident to wear non-slip socks when ambulating. Record review of the facility "Interdisciplinary	S3026		

Kansas Department on Aging

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S3026	Continued From page 2 Progress Notes" dated 03/21/22 thru 07/05/22 revealed the following entries: On 03/21/22 at 07:30 revealed the resident admitted to the memory care assisted living after she discharged from rehabilitation today. The resident walked around the unit all evening with her walker. The resident had orders for physical therapy, occupational therapy and speech therapy to evaluate and treat due to recent hip fracture with falls. On 04/19/22 at 6:30 PM revealed the resident was found on the floor. Staff found the resident lying face down, on the floor in front of her restroom and upon assessment the resident complained of head pain and pain all over. Staff immediately called 911. The record lacked documentation of the resident's return to the facility and/or any fall intervention implemented as a result of the fall. On 06/11/22 at 02:15 PM and signed by Licensed Nurse (LN) C revealed the resident was found on the floor, on the left side, stating she hit her head against the cabinet. The note further revealed the resident was sent to the emergency room. On 06/11/22 at 6:30 PM and signed by LN C revealed the resident had returned from the emergency room and the "Computed Tomography" (CT) scan of the head was negative for findings. Review of the resident's record lacked evidence of any new interventions were placed as a result of the fall dated 06/11/22.	S3026		

Kansas Department on Aging

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S3026	Continued From page 3 On 06/13/22 at 08:20 AM revealed the resident was seated on the edge of the bed in an unsafe position when staff walked in to check on resident, she was very close to slipping off the edge of the bed. Resident was able to reposition self without problems. On 06/13/22 at 02:25 PM revealed the resident was found on the floor of her bedroom, lying flat on her back. The resident stated her lower back and right hip were killing her and transferred her by emergency medical services to a local medical center. On 06/13/22 at 09:25 PM revealed staff called the hospital for an update and noted the resident was being admitted for displaced right hip. Review of the resident's record lacked evidence any new interventions were placed as a result of the fall dated 06/13/22. On 06/16/22 at 06:30 PM revealed the resident returned to facility following right hip dislocation. The discharge paperwork stated the resident was a stand by assist with walker. On 06/16/22 at 08:45 PM revealed the Certified Nurse Aide (CNA) found the resident on the floor of her room. Twenty minutes prior to the fall the resident was anxious and refused going with staff. Facility staff reported checking on the resident multiple times in approximately twenty minutes. Staff reported they heard a loud bang and the resident yelling for help. The resident's recliner had moved and was still reclined. The resident had fallen straight out of the recliner and landed on her left side/left face. The resident had a large pool of blood under her head. Resident was sent to the local emergency room and was	S3026		

Kansas Department on Aging

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S3026	Continued From page 4 admitted to the hospital. On 06/21/2022 at 12:50 PM revealed the resident is admitted to a skilled rehabilitation facility. On 07/05/22 at 12:00 PM revealed resident returned to the facility. The note documented the resident as up with walker and gait belt at first, however the resident ambulated without difficulty. Observation on 07/20/22 at 8:50 AM resident gets up from the breakfast table and walks unassisted with her walker to her room. The resident records lacked an updated FCS and NSA/HSP to include additional fall interventions after the resident returned to the facility from a skilled nursing stay. Interview on 07/25/2022 at 11:00 AM with LN E confirmed the resident record lacked fall interventions on the NSA/HSP. - Record review on 07/20/22 for R 115 revealed an admission date of 11/12/21 with diagnoses of type two diabetes, osteoporosis, hypertension and glaucoma. Record review on 07/20/22 of the FCS dated 11/12/21 identified the resident was independent in dressing, toileting, transferring and walking/mobility. She had impaired memory recall, was understandable to others and she understood others. She used a walker mobility device. Record review on 07/20/22 of the combined NSA/HSP identified the following healthcare services/instructions provided by the facility;	S3026		

Kansas Department on Aging

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S3026	Continued From page 5 under the transportation needs and preferences it stated the resident is not allowed to leave the building unsupervised, resident is alert and oriented to person and place with confusion at times. Staff will encourage and assist resident to activities. Resident was independent with her transferring and mobility, she occasionally used a walker or cane for ambulation, she was independent with toileting. She required the assistance of one staff member for showering and dressing/undressing. Record review of the facility "Interdisciplinary Progress Notes" dated 11/19/21 thru 02/18/2022 revealed the following entries: On 11/14/21 at 09:10 (AM/PM not indicated) revealed CNA reported resident had door locked and chair placed under the handle. On 12/14/21 at 08:20 PM revealed the resident returned from the emergency room and daughter stated they think she fell at some point as she has a bruise to the back of her left shoulder. Review of Progress Note from "Advanced Practice Registered Nurse" (APRN) F dated 11/19/21 recorded resident had some short-term memory loss. Review of Progress Note from "Advanced Practice Registered Nurse" (APRN) F dated 12/20/21 revealed R 115 was seen on 12/14/2021 for left sided chest pain in the emergency room. She was readmitted back to the facility indicating she had a fall at some point as she had bruising to the left shoulder. On exam resident was pleasantly confused. She was unable to fully	S3026		

Kansas Department on Aging

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S3026	Continued From page 6 assess and complete review of symptoms secondary to resident's dementia/cognitive impairment. On 02/18/22 at 07:30 PM revealed the resident was very upset. She asked me to "hide her" and stated people are out to get her. She is wanting to stay very close to staff and not go to her room. On 02/23/2022 at 09:15 PM revealed at approximately 4:30 PM Staff was notified that resident had eloped and left the facility. Staff brought her back where she was warmed up. She stated that she didn't know why she left or where she was trying to go. She was transferred by ambulance to the hospital for evaluation. On 02/24/22 at 06:00 AM resident was returned to the facility accompanied by her daughter, daughter was staying with resident thru the night shift. Record review of the emergency room assessment dated 02/23/22 and signed by emergency provider G revealed under the complaint the resident has a history of dementia, she eloped out doors and took a walk. Patient fell striking her nose on the ground. Family wanted patient checked out for increased confusion. Patient was alert, warm talkative, but did not recall why she left or when. She did know her age and where she was. Nursing home staff told emergency services that patient seemed a little more confused today and her family wanted her assessed. Record review of the Urine Chemistry obtained on 02/23/22 at 06:47 PM by the hospital revealed the resident was negative for a urinary tract	S3026		

Kansas Department on Aging

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S3026	Continued From page 7 infection. Record review of the facility provided investigation dated 02/23/2022 of the resident elopement revealed the following: A statement from Senior Director H revealed at approximately 04:30 PM an individual from the independent living villas came in the main entrance of the facility where an event was being held and reported that they saw an older woman walking outside by their villa and was heading up the hill in only a red jacket. Senior Director H and the private individual drove around the parking lot and saw the resident across the street in the grass bent at the waist with her hands on her knees. It was approximately 18 degrees Fahrenheit. She reported once in the car the resident was able to state her name, she was unsure where she lived. She said she needed help but did not want to be locked up anymore. Staff statements within the facility investigation revealed "Certified Medication Aide" (CMA) H stated she thought the resident was attending the social. Review of the facility security camera times revealed the following; On 02/23/2022 at 04:15 PM resident was seen walking down the assisted living hall toward the Lodge lobby. 04:30 PM resident was seen exiting Door C of the lower Lodge area. She appeared to walk to the left once outside. Interview on 07/21/22 with Administrator K confirmed the resident walked out the south door of the main entrance of the facility, around the east side of the facility, across the parking lot to the north east, across the street to the north east and was found on the grass in front of the	S3026		

Kansas Department on Aging

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S3026	Continued From page 8 hospice house located across the street to the north of the facility campus. Interview on 07/25/22 at 11:00 AM with LN E and administrator K confirmed the staff did not assist the resident to the activity. The administrator failed to ensure the licensed nurse placed interventions for R 111 who had multiple falls. This failure of interventions allowed R 111 to continue to fall with one resulting in the dislocation of the right hip and a facial laceration. The administrator further failed to acknowledge a change in cognition/decision making for R 115 which resulted in the resident leaving the facility without staff knowledge in 18-degree Fahrenheit weather wearing only a red jacket, having an unwitnessed fall resulting in an emergency room visit to assess a facial injury.	S3026		
S3215 SS=D	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and	S3215		

Kansas Department on Aging

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S3215	Continued From page 9 biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) The facility reported a census of 56 residents. The facility reported a census of 56 residents. Licensed Nurse (LN) E identified two secured memory care units. The Azalea unit had a census of 11 residents and the Briar unit had a census of 11 residents. Based on observation and interview the administrator failed to ensure the licensed nurses or certified medication aides properly secured and stored medications and biologicals in accordance with recommendations of stated regulations for the two secured memory care units. Findings included: - Record review on 07/19/2022 of the facility provided resident roster, revealed the facility managed medications for all the residents in the	S3215		

Kansas Department on Aging

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S3215	Continued From page 10 secured memory care units. On 07/20/22 at 09:30 AM tour of the Briar locked memory care unit revealed the following "Over the Counter" (OTC) medications in the unsecured bathroom cabinets in five of the resident rooms: 1 bottle of allergy relief eye drops (medication for dry eyes) 1 bottle of Icy Hot (topical medication for pain) 1 bottle of Theraworx Relief (topical medication for pain) 1 bottle of Gentle Tears (medication for dry eyes) 1 bottle of pain Relief Gel (medication for pain) 1 bottle of Thera Tears (medication for dry eyes) 1 packet of Bio Freeze (medication for muscle pain) On 07/20/22 at approximately 10:00 AM Tour of the Azalea locked memory care unit revealed the following prescribed medication in the unsecured bathroom cabinet of 1 resident room: 1 bottle of Nystop powder (medication for fungal infections) with a prescription label. Interview on 07/20/22 with LN E revealed all OTC's/prescriptions and biologicals are to be locked on the medication cart. The administrator failed to ensure the licensed nurses or certified medication aides properly secured and stored medications and biologicals in accordance with recommendations of stated regulations for the two secured memory care units.	S3215		
S3320 SS=D	28-39-254 CONSTRUCTION	S3320		

Kansas Department on Aging

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S3320	Continued From page 11 (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254 (a) The facility reported a census of 56 residents. Licensed Nurse (LN) E identified two secured memory care units. The Azalea unit had a census of 11 residents and the Briar unit had a census of 11 residents. Based on observation, interview and record review, the administrator failed to ensure the facility was equipped and maintained to protect the health and safety of residents regarding chemicals, when unsecured chemicals were found in four resident unsecured bathroom cabinets.	S3320		

Kansas Department on Aging

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S3320	Continued From page 12 Findings Included: - On 07/18/22 at 09:00 AM during initial tour of the facility, an observation in the Briar locked memory care unit revealed a curtain hanging down covering the open area under the kitchen sink. Behind the curtain was a clear plastic cup filled half way with a blue, thick liquid. Interview with administrator K stated he confirmed with staff member L the liquid was dish washing soap. Administrator K confirmed the chemicals should be behind a locked cabinet. On 07/20/22 at 09:30 AM tour of the Briar locked memory care unit, observed the following chemicals in the unsecured bathroom cabinets in 3 of the resident rooms: 1 can of Febreze air freshener 1 can of Glade Fall Night Long air freshener 1 bottle of Equate nail polish remover On 07/20/22 at approximately 10:00 AM during tour of the Azalea locked memory care unit, observed the following chemicals in the unsecured bathroom cabinet of 1 resident room: 1 bottle of Equate nail polish remover. Interview on 07/20/22 with LN E revealed all chemicals are to be locked in a cabinet. Record review on 07/20/22 of the facility Procurement And Storage of Equipment Products And Supplies dated 02/09/2022 revealed on page two, under the storage heading, were the following statements: 5. "Ensure that all products (chemicals and	S3320		

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S3320	Continued From page 13 disinfectants) are labeled and stored in a manner that eliminates risk of improper use, contamination, inhalation, skin contact or personal injury. 6. "Housekeeping equipment, products and supplies should not be stored in resident rooms or units. Store these items in a locked cabinet and/or storage rooms as appropriate. The administrator failed to ensure the facility was equipped and maintained to protect the health and safety of residents regarding unlocked chemicals when two cans of air freshener and two bottles of nail polish remover were observed unsecured, in 4 resident rooms of a secured memory care unit.	S3320		