| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N046065 | A. BUILDING: _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

| (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 |
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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of an abbreviated survey with complaint investigations 120948, 122158, 122608, 123639, 123633 at the above named assisted living facility conducted on 11-28-17, 11-29-17 and 11-30-17. | S 000 | | |
| S3080 SS=F | 26-41-201 (a) (b) Functional Capacity Screen on Admission<br><br>a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department.<br>(b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-201(a)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on record review and interview for 1 (#3) of 6 sampled residents and potentially affecting all residents, the administrator failed to ensure a licensed nurse recorded the individual's functional capacity findings on a screening form which included each | S3080 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S3080 | Continued From page 1<br>element and definition specified by the department.<br><br>Findings included:<br><br>- Record review for resident #3 revealed admission on 6-10-13 with diagnoses Debility, Dementia, Gastroesophageal Reflux Disease, and Glaucoma.<br><br>The "(Facility) LOC (Level of Care) Assessment" conducted on 9-29-17 lacked documentation per the Kansas Resident Functional Capacity Screen Manual:<br>Primary Reason for Screen (Admission, Significant Change, Annual)<br>Birthdate completed as 00/00/0000<br><br>The Assessment failed to specifically identify "Activities of Daily Living" as Bathing, Dressing, Toileting, Transfer, Walking/Mobility, Eating and "Instrumental Activities of Daily Living" as Meal Preparation, Shopping, Money Management, Transportation, Use of Telephone, Laundry/Housekeeping, Management of Medications and Management of Treatments. The form lacked coding as defined by the department. (0 Independent; 1 Supervision; 2 Physical Assistance Needed; 3 Unable to perform).<br><br>The form further lacked documentation of:<br>Bladder Continence with coding as defined by the department (0 Continent; 1 Usually Continent; 2 Occasionally Incontinent; 3 Frequently Incontinent; 4 Incontinent);<br>Cognition - Memory Recall (Short Term Memory; Long Term Memory; Memory/Recall; Decision-Making) with coding as defined by the department; | S3080 | | |

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| S3080 | Continued From page 2<br>Communication (Expresses information content; Ability to understand others, verbal information, however able) with coding as defined by the department.<br><br>Interview on 11-28-17 at 3:08 pm with Administrative Nurse A confirmed some elements were not included on the facility's Level of Care Assessment tool and further confirmed this tool lacked coding as defined by the Kansas Functional Capacity Screen Manual. Stated facility is under new management which will be utilizing electronic health records and this format is to be used for all residents.<br><br>For Resident #3 and potentially affecting all residents, the administrator failed to ensure a licensed nurse recorded the individual's functional capacity findings on a screening form which included each element and definition specified by the department. | S3080 | | |
| S3081 SS=D | 26-41-201 (c) Functional Capacity Screen Reassessment<br><br>(c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements:<br>(1) At least once every 365 days;<br>(2) following any significant change in condition as defined in K.A.R. 26-39-100; and<br>(3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant.<br><br>This REQUIREMENT is not met as evidenced by: | S3081 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| S3081 | Continued From page 3<br>KAR 26-41-202(d)(1)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on record review and interview for 1 (#8) of 6 sampled residents, the administrator failed to ensure designated facility staff shall conduct a screening to determine the resident's functional capacity at least every 365 days.<br><br>Findings included:<br><br>- Record review for Resident #8 revealed admission on 5-23-14 with unknown diagnoses.<br><br>The Functional Capacity Screen (FCS) dated 7-28-16 recorded resident required health care services.<br><br>Interview on 11-28-17 at 4:45 pm with Administrative Nurse A stated this was the only FCS he/she could locate and confirmed the FCS lacked documentation of review at least every 365 days.<br><br>For Resident #8, the administrator failed to ensure designated staff conducted a screening to determine the resident's functional capacity at least once every 365 days. | S3081 | | |
| S3092 SS=D | 26-41-202 (d) Negotiated Service Agreement Revisions<br><br>(d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every | S3092 | | |

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|---|---|---|---|
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| S3092 | Continued From page 4<br>365 days;<br>(2) following any significant change in condition, as defined in K.A.R. 26-39-100;<br>(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and<br>(4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(d)(1)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on record review and interview for 1 (#8) of 6 sampled residents, the administrator failed to ensure the review and, if necessary, revision of each negotiated service agreement at least every 365 days.<br><br>Findings included:<br><br>- Record review for Resident #8 revealed admission on 5-23-14 with unknown diagnoses.<br><br>The Functional Capacity Screen (FCS) dated 7-28-16 recorded resident required health care services.<br><br>The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 7-28-16 recorded services for facility staff to administer all medications. Assistance with bathing per | S3092 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S3092 | Continued From page 5<br>resident's request. The NSA lacked documentation of review and, if necessary revision at least once every 365 days.<br><br>Interview on 11-28-17 at 4:45 pm with Administrative Nurse A stated this was the only NSA/HCSP he/she could locate and confirmed the NSA lacked documentation of review at least every 365 days.<br><br>For Resident #8, the administrator failed to ensure the review and, if necessary, revision of each negotiated service agreement at least every 365 days. | S3092 | | |
| S3101 SS=E | 26-41-202 (h) NSA Signatures<br><br>(h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(h)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on record review and interview for 4 (#3, #5, #6, #7) of 6 sampled residents, the administrator failed to ensure each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator shall | S3101 | | |

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| S3101 | Continued From page 6 | S3101 | | |

ensure that a copy of the agreement is provided to the resident or the resident's legal representative.

Findings included:

- Record review for resident #3 revealed admission on 6-10-13 with diagnoses Debility, Dementia, Gastroesophageal Reflux Disease, and Glaucoma. The Functional Capacity Screen dated 8-4-16 recorded resident required health care services.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 8-4-16 recorded "full body" services for bathing, dressing; assistance with toileting for frequent incontinence and facility staff to administer all medications. Resident to have stand by assist when using walker and assist of 1 staff with wheelchair. The NSA/HCSP documented resident had "periods of confusion" and "poor recall at times", also is alert and oriented to person, place and time. Special Monitoring for incontinence.

The NSA/HCSP was signed by the Administrative Staff D and a licensed nurse. The NSA lacked signature of the resident's legal representative.

For Resident #3, the administrator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement.

- Record review for Resident #5 revealed admission on 4-1-17 with diagnoses Hypertension, Insomnia, and Right Leg Wound. The Functional Capacity Screen dated 5-5-17 recorded resident required health care services.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| S3101 | Continued From page 7<br><br>The Negotiated Service Agreement dated 5-5-17 recorded services for assistance with bathing and dressing; and facility staff to administer all medications and treatments. Staff to provide supervision of transfers and assist resident when ambulating with walker through crowded areas.<br><br>The NSA/HCSP lacked documentation of signatures of a licensed nurse, administrator and resident and/or his/her legal representative.<br><br>Interview on 11-28-17 at 3:46 pm with Administrative Nurse A confirmed the NSA/HCSP lacked signatures.<br><br>For Resident #5, the administrator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement.<br><br>- Record review for Resident #6 revealed admission on 2-14-14 with diagnoses Depression, Hypothyroidism, Glaucoma, Hyperlipidemia, Atherosclerotic Cardiovascular Disease, Diverticulitis, and Dementia with Delusions. The Functional Capacity Screen dated 2-1-17 recorded resident required health care services.<br><br>The Negotiated Service Agreement/Healthcare Service Plan (NSA/HCSP) dated 2-1-17 recorded services for "full body" assistance with bathing and dressing. Resident identified to be at risk for skin breakdown, staff to monitor skin during bathing and report findings to nurse. Resident required assistance with pericare - staff to supervise, provide pericare and to monitor skin during pericare and notify charge nurse of skin | S3101 | | |

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|---|---|---|---|
| | N046065 | A. BUILDING: _____ B. WING _____ | 11/30/2017 |

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|---|---|
| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

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|---|---|---|---|---|
| S3101 | Continued From page 8 | S3101 | | |

changes. Resident oriented to person only with impaired cognition, wanders throughout special care unit. Facility staff administer medications.

The NSA/HCSP was signed by Administrative Nurse A. The NSA/HCSP lacked documentation of signature of the resident's legal representative.

Interview on 11-28-17 at 4:11 pm with Administrative Nurse A confirmed the NSA/HCSP lacked signature of the resident's legal representative.

For Resident #6, the administrator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement.

- Record review for Resident #7 revealed admission on 1-26-15 with diagnoses Alzheimer's Disease, Chronic Obstructive Pulmonary Disease and Gastroesophageal Reflux Disease. The Functional Capacity Screen dated 2-2-17 recorded resident required health care services.

The Negotiated Service Agreement/Health Care Service Plan dated 2-22-17 recorded full body assistance with bathing and dressing, assistance with toileting every two hours and supervision of eating. Facility staff to administer all medications. Special Monitoring indicated for Wandering/elopement, Dementia, Inappropriate behaviors and Incontinence.

The NSA/HCSP was signed by Administrative Nurse A and Administrative Staff D. The NSA/HCSP lacked documentation of signatures of resident's legal representative.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N046065 | A. BUILDING: _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

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| S3101 | Continued From page 9<br><br>Interview on 11-28-17 at 4:35 pm with Administrative Staff A confirmed the NSA/HCSP lacked documentation of the resident's legal representative.<br><br>For Resident #7, the administrator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement. | S3101 | | |
| S3130 SS=D | 26-41-203 (d) Special Care Services<br><br>(d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met:<br>(1) Written policies and procedures are developed and are implemented for the operation of the special care section or facility.<br>(2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility.<br>(3) A written order from a medical care provider is obtained for admission.<br>(4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility.<br>(5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in | S3130 | | |

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|---|---|---|---|
| | N046065 | A. BUILDING: _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

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| S3130 | Continued From page 10<br>writing, of the available services and programs that are specific to the needs of the resident.<br>(6) Direct care staff are present in the special care section or facility at all times.<br>(7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records.<br>(8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility.<br>(9) The control of exits in the special care section is the least restrictive possible for the residents in that section.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-203(d)(5)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on observation, record review and interview for 1 (#3) of 6 sampled residents, the administrator failed to ensure that before the resident's admission to the special care unit: the resident's legal representative was informed, in writing, of the available services and programs that were specific to the needs of resident #3.<br><br>Findings included: | S3130 | | |

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|---|---|---|---|---|
| S3130 | Continued From page 11<br><br>- Observation during tour of the facility accompanied by Administrative Nurse A on 11-28-17 at 10:34 am revealed a locked unit designated as a special care unit. All doors required a code to be entered on a key pad to exit from the unit. To exit from the unit kitchen, a key was required.<br><br>- Record review for resident #3 revealed admission on 6-10-13 with diagnoses Debility, Dementia, Gastroesophageal Reflux Disease, and Glaucoma.<br><br>The Functional Capacity Screen dated 8-4-16 recorded resident required physical assistance with bathing, dressing, toileting, walking/mobility and management of medications/treatments; supervision with transfers and independent with eating. Frequently incontinent of bladder. No problems with cognition documented. Current problems/risks identified included falls/unsteadiness. Resident uses wheelchair and walker.<br><br>The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 8-4-16 recorded "full body" services for bathing, dressing; assistance with toileting for frequent incontinence and facility staff to administer all medications. Resident to have stand by assist when using walker and assist of 1 staff with wheelchair. The NSA/HCSP documented resident had "periods of confusion" and "poor recall at times", also is alert and oriented to person, place and time. Special Monitoring for incontinence. The NSA/HCSP failed to identify resident for "Wandering/Elopement" and to provide instructions to certified staff to manage resident's elopement risk. | S3130 | | |

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|---|---|---|---|---|
| S3130 | Continued From page 12<br><br>Nurse's Notes dated 6-27-17 on the 6:00 am to 2:00 pm shift stated, "Resident witnessed to be outside the facility sitting on his/her wheelchair. When asked he/she stated that he/she just wanted to sit...and get some sunshine. Resident was helped back in the facility. (Physician), (Family member) and Director of Nursing were notified. Resident was taken to the back yard to continue basking in the sun. Denies any pain. No injury noted. Received a new order from (physician) that resident may be taken to the special care unit (memory care)..." Signed by Licensed Staff B.<br><br>Interview on 11-28-17 at 3:08 pm with Administrative Nurse A stated "because of his/her elopement risk", the resident moved from assisted living to the secure memory care unit on 8-31-17 when a room became available and until the move, resident would visit the memory care during the day.<br><br>Interview on 11-29-17 at 12:55 pm with Administrative Nurse A stated, "I don't believe there was a signed agreement, I'm sure there was not" between the facility and the resident's legal representative informing him/her of the available services and programs that were specific to the resident on the secured memory care unit.<br><br>The administrator failed to ensure before resident #3's admission to the special care section of the facility: the resident's legal representative was informed, in writing, of the available services and programs that were specific to the needs of resident #3. | S3130 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

| (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 |
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| S3155 | Continued From page 13 | S3155 | | |
| S3155 SS=E | 26-41-204 (a) Health Care Services<br><br>. (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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-204(a)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on record review and interview for 2 (#3, #6) of 6 sampled residents, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the cognitively impaired residents.<br><br>Findings included:<br><br>- Record review for resident #3 revealed admission on 6-10-13 with diagnoses Debility, Dementia, Gastroesophageal Reflux Disease, and Glaucoma.<br><br>The Functional Capacity Screen dated 8-4-16 recorded resident required physical assistance with bathing, dressing, toileting, walking/mobility | S3155 | | |

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| S3155 | Continued From page 14 | S3155 | | |

and management of medications/treatments; supervision with transfers and independent with eating. Frequently incontinent of bladder. No problems with cognition documented. Current problems/risks identified included falls/unsteadiness. Resident uses wheelchair and walker.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 8-4-16 recorded "full body" services for bathing, dressing; assistance with toileting for frequent incontinence and facility staff to administer all medications. Resident to have stand by assist when using walker and assist of 1 staff with wheelchair. The NSA/HCSP documented resident had "periods of confusion" and "poor recall at times", also is alert and oriented to person, place and time. Special Monitoring for incontinence.

Under "Special Monitoring" section, the NSA/HCSP failed to identify resident for "Wandering/Elopement" and to provide instructions to certified staff to manage resident's elopement risk.

Nurse's Notes dated 6-27-17 on the 6:00 am to 2:00 pm shift stated, "Resident witnessed to be outside the facility sitting on his/her wheelchair. When asked he/she stated that he/she just wanted to sit...and get some sunshine. Resident was helped back in the facility. (Physician), (Family member) and Director of Nursing were notified. Resident was taken to the back yard to continue basking in the sun. Denies any pain. No injury noted. Received a new order from (physician) that resident may be taken to the special care unit (memory care)..." Signed by Licensed Staff B.

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| S3155 | Continued From page 15<br><br>Interview on 11-28-17 at 3:08 pm with Administrative Nurse A confirmed the NSA/HCSP lacked interventions to address the resident's elopement risk. Stated the resident moved from assisted living to the secure memory care unit on 8-31-17 when a room became available and until the move, resident would visit the memory care during the day. Stated the resident moved out of the facility on 10-12-17. Confirmed the NSA/HCSP lacked documentation of interventions to keep resident safe from the time of his/her elopement on 6-27-17 until he/she moved from the facility on 10-12-17.<br><br>For Resident #3, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident who was an elopement risk.<br><br>- Record review for Resident #6 revealed admission on 2-14-14 with diagnoses Depression, Hypothyroidism, Glaucoma, Hyperlipidemia, Atherosclerotic Cardiovascular Disease, Diverticulitis, and Dementia with Delusions.<br><br>The Functional Capacity Screen dated 2-1-17 recorded resident required physical assistance with bathing, dressing, toileting, transfers and management of medications/treatments; independent with walking/mobility and eating. Occasionally incontinent of bladder. Problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks included unsteadiness, impaired decision-making, wandering and socially inappropriate disruptive behavior. | S3155 | | |

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| S3155 | Continued From page 16<br><br>The Negotiated Service Agreement/Healthcare Service Plan (NSA/HCSP) dated 2-1-17 recorded services for "full body" assistance with bathing and dressing. Resident identified to be at risk for skin breakdown, staff to monitor skin during bathing and report findings to nurse. Resident required assistance with pericare - staff to supervise, provide pericare and to monitor skin during pericare and notify charge nurse of skin changes. Resident oriented to person only with impaired cognition, wanders throughout special care unit. Facility staff administer medications.<br><br>"Under Special Monitoring" section, the NSA/HCSP failed to identify skin integrity and to provide interventions to manage resident's potential for and then actual impaired skin integrity.<br><br>Nurses's Notes revealed the following:<br>11-3-17 at unknown time: Documentation of the home health wound care nurse visit stated, "Transfer back to bed with moderate assist. Ulcer left buttock close to gluteal cleft. 1 x 1.5 x 0.1 cm (centimeters), stage II. No dressing. Noted staff has been applying barrier cream to areas liberally. (Resident) is incontinent. Because of location of ulcer, unable to cover with hydrocolloid or Tegaderm absorbent. Reapplied barrier cream...reported to (facility) certified nurse aide of findings, and recommendations. Will call physician to conference..." Signed by home health agency licensed nurse.<br>11-3-17 at 4:00 pm: New order for RoHo (air-filled, pressure relieving) cushion, labs serum iron level, transferrin level, ferritin level. Continue with buttock cream with petroleum and zinc daily and with brief changes, keep clear and dry. Home health will follow in 1 week per physician." Signed by Licensed Staff C. | S3155 | | |

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| S3155 | Continued From page 17<br>11-6-17 at 10:57 am: Documentation of home health wound care nurse visit stated, "Noted new area to left buttocks, unstageable 2.1 x 1.5 x 0.1 cm 50% slough/eschar. Cleansed with wound cleanser. Redressed with Tegaderm absorbent. Right buttocks 2.2 x 1 x 0.1 cm. Redressed with barrier cream. Report given in person to (physician) who agrees with plan of care and agency parameters." Signed by home health agency licensed nurse.<br>11-6-17 at unknown time: "Physical Therapy/Occupational Therapy evaluate resident for wheelchair cushion and soft mattress. Place pillow in wheelchair per (physician)." Signed by Licensed Staff C.<br>11-8-17 at 4:00 pm: "Faxed/called in orders to (home health agency) for physical therapy/occupational therapy for wheelchair cushion and soft mattress." Signed by Licensed Staff B.<br>11-10-17 at unknown time: Documentation of the home health wound care nurse visit stated, "(Resident) back to bed with moderate assistance. Cleansed wound with wound cleanser. Right buttocks unstageable. Pressure ulcer measures 1.5 x 2.2 x 0.1 cm. Decline. Left buttocks pressure ulcer measures 1.5 x 2.2 x 0.1 cm, unstageable. Decline. No barrier cream available at facility at this time. Covered both areas with bordered foam to protect. Will bring staff Tegaderm absorbent for staff to replace dressings with..." Signed by home health agency licensed nurse.<br>11-10-17 at 3:00 pm: "New order per (physician) for hospital bed and low air loss mattress, RoHo cushion." Signed by Licensed Staff C.<br>11-13-17 at unknown time: Documentation of the home health wound care nurse visit stated, "Noted (resident) in bed and soaked with urine...Removed top layer of chux. Noted no | S3155 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S3155 | Continued From page 18 | S3155 | | |

dressings on ulcers or buttocks. Left buttocks wound bed without slough. Right buttocks ulcer noted to be softened, slough loosening. Cleansed with wound cleanser. Right 1 x 1.5 x 0.1 cm. Left 1.7 x 1.3 x 0.1 cm. Dressings are not staying in place due to location of ulcers. Will discontinue dressings and return to barrier cream twice and day with pericare or after bowel movements. Orders written." Signed by home health agency licensed nurse.
11-15-17 at 11:30 am: Resident was discharged from our facility..." Signed by Licensed Staff B.

Physician Progress Note dated 11-3-17: Pressure Ulcer buttocks chronic. Gait impairment, Wheelchair bound...alert pleasant confused, obese. Stage 3 pressure ulcer buttocks. Unable to use cane or walker for all ADLs (activities of daily living). Needs wheelchair. Needs RoHo cushion and off loading mattress. Plan: physical therapy/occupational therapy/skilled nursing, wheelchair cushion, mattress, continue current treatment with dressings. Consider hospice.

Interview on 11-28-17 at 4:11 pm with Administrative Nurse A confirmed the resident had an open area on buttocks which was acquired at the facility. Confirmed the NSA/HCSP lacked documentation of interventions to address resident's risk for skin impairment. Further confirmed after the resident experienced actual impairment of skin, the NSA/HCSP lacked documentation of interventions to address the resident's actual impairment of skin integrity including use of a RoHo cushion, hospital bed with low air loss mattress, wound care provided by a home health agency, instructions to staff for repositioning, any dietary approaches and monitoring by facility licensed staff.

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| S3155 | Continued From page 19<br><br>For Resident #6, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident with the potential for skin impairment who then experienced actual skin impairment. | S3155 | | |
| S3258 SS=F | 26-41-105 (e) Electronic Medical Record<br><br>(e) If electronic medical records are used, each administrator or operator shall ensure the development of policies addressing the following requirements:<br>(1) Protection of electronic medical records, including entries by only authorized users;<br>(2) safeguarding of electronic medical records against unauthorized alteration, loss, destruction, and use;<br>(3) prevention of the unauthorized use of electronic signatures;<br>(4) confidentiality of electronic medical records; and<br>(5) preservation of electronic medical records.<br>(f) Each resident record shall contain at least the following:<br>(1) The resident's name;<br>(2) the dates of admission and discharge;<br>(3) the admission agreement and any amendments;<br>(4) the functional capacity screenings;<br>(5) the health care service plan, if applicable;<br>(6) the negotiated service agreement and any revisions;<br>(7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency;<br>(8) the name, address, and telephone number of the legal representative or the individual of the | S3258 | | |

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| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

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| S3258 | Continued From page 20<br>resident's choice to be notified in the event of a significant change in condition;<br>(9) the name, address, and telephone number of the case manager, if applicable;<br>(10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(e)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on record review and interview for all residents, the administrator failed to ensure the development of policies addressing the following requirements: 1. Protection of electronic medical records; 2. safeguarding of electronic medical records against unauthorized alteration, loss, destruction, and use; 3. prevention of the unauthorized use of electronic signatures; 4. confidentiality of electronic medical records; and 5. preservation of electronic medical records.<br><br>Findings included:<br><br>- On 11-28-17 at 9:35 am during entrance interview with Administrative Nurse A, stated facility is under new management since around June 2017. Stated they are transitioning to an electronic medical record system. | S3258 | | |

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|---|---|
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| S3258 | Continued From page 21<br><br>On 11-30-17 at 1:19 pm confirmed the facility had failed to develop policies for the use of the electronic medical records.<br><br>For all residents, the administrator failed to ensure the development of policies for electronic medical records. | S3258 | | |
| S3261 SS=E | 26-41-105 (f) (11) Resident Record Documentation of Incidents<br><br>(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<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-105(f)(11)<br><br>The facility reported a census of 55 residents with 13 residents residing in the special care unit. The sample included 6 residents (3 current residents and 3 discharged residents). Based on record review and interview for 2 (#3, #6) of 6 sampled residents, the administrator failed to ensure 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.<br><br>Findings included:<br><br>- Record review for resident #3 revealed admission on 6-10-13 with diagnoses Debility, | S3261 | | |

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|---|---|---|---|
| | N046065 | A. BUILDING: _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

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| S3261 | Continued From page 22<br>Dementia, Gastroesophageal Reflux Disease, and Glaucoma.<br><br>The Functional Capacity Screen dated 8-4-16 recorded resident required physical assistance with bathing, dressing, toileting, walking/mobility and management of medications/treatments; supervision with transfers and independent with eating. Frequently incontinent of bladder. No problems with cognition documented. Current problems/risks identified included falls/unsteadiness. Resident uses wheelchair and walker.<br><br>The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 8-4-16 recorded "full body" services for bathing, dressing; assistance with toileting for frequent incontinence and facility staff to administer all medications. Resident to have stand by assist when using walker and assist of 1 staff with wheelchair. The NSA/HCSP documented resident had "periods of confusion" and "poor recall at times", also is alert and oriented to person, place and time. Special Monitoring for incontinence.<br><br>Nurse's Notes dated 6-27-17 on the 6:00 am to 2:00 pm shift stated, "Resident witnessed to be outside the facility sitting on his/her wheelchair. When asked he/she stated that he/she just wanted to sit...and get some sunshine. Resident was helped back in the facility. (Physician), (Family member) and Director of Nursing were notified. Resident was taken to the back yard to continue basking in the sun. Denies any pain. No injury noted. Received a new order from (physician) that resident may be taken to the special care unit (memory care)..." Signed by Licensed Staff B. | S3261 | | |

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|---|---|---|---|
| | N046065 | A. BUILDING: _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

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| S3261 | Continued From page 23<br><br>On 6-28-17 on the 6:00 am to 2:00 pm shift stated: "Resident continues to be monitored. Has been assisted with ADL's (activities of daily living), taken to the special care unit for the day. No complaints. Will continue to monitor." Signed by Licensed Staff B.<br><br>The record lacked any further documentation until 10-6-17 (observed with blood in his/her urine, immediate urinalysis ordered, resident refused to give urine sample and antibiotic therapy started), 10-9-17 (new order for labwork and monitoring of vital signs) and 10-12-17 (discharge from the facility).<br><br>The record lacked documentation of a head to toe assessment performed by the licensed nurse after the elopement on 6-27-17 including documentation of additional actions taken to address resident's elopement risk and resident's response to those actions. The record further lacked documentation of resident's move from the assisted living to the secured special care unit and follow up of the urinary tract infection including worsening or resolution of symptoms.<br><br>Interview on 11-28-17 at 3:08 pm with Administrative Nurse A confirmed the record lacked documentation of a full assessment when brought back inside facility. Stated after the elopement incident on 6-27-17, staff were instructed to "have eyes on him/her" when ever resident was not in his/her room. Resident "had to be in view (of staff) when he/she was not in his/her room" and resident would "visit the special care unit daily during the day" while waiting for a room to become available. Stated the resident moved from assisted living to the secure memory care unit on 8-31-17. Confirmed the record lacked documentation of daily visits to the special | S3261 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

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| S3261 | Continued From page 24 | S3261 | | |

care unit and move to the unit on 8-31-17 including resident's response to the move. Further confirmed the record lacked documentation of follow up of resident's urinary tract infection.

For Resident #3, the administrator failed to ensure documentation of assessments following an elopement and an illness, actions taken to address elopement risk, results of the actions and resident's move from the assisted living to the secured special care unit.

- Record review for Resident #6 revealed admission on 2-14-14 with diagnoses Depression, Hypothyroidism, Glaucoma, Hyperlipidemia, Atherosclerotic Cardiovascular Disease, Diverticulitis, and Dementia with Delusions.

The Functional Capacity Screen dated 2-1-17 recorded resident required physical assistance with bathing, dressing, toileting, transfers and management of medications/treatments; independent with walking/mobility and eating. Occasionally incontinent of bladder. Problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks included unsteadiness, impaired decision-making, wandering and socially inappropriate disruptive behavior.

The Negotiated Service Agreement/Healthcare Service Plan (NSA/HCSP) dated 2-1-17 recorded services for "full body" assistance with bathing and dressing. Resident identified to be at risk for skin breakdown, staff to monitor skin during bathing and report findings to nurse. Resident required assistance with pericare - staff to

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|---|---|---|---|---|
| S3261 | Continued From page 25 | S3261 | | |

supervise, provide pericare and to monitor skin during pericare and notify charge nurse of skin changes. Resident oriented to person only with impaired cognition, wanders throughout special care unit. Facility staff administer medications.

Nurses's Notes revealed the following:
11-3-17 at unknown time: Documentation of the home health wound care nurse visit stated, "Transfer back to bed with moderate assist. Ulcer left buttock close to gluteal cleft. 1 x 1.5 x 0.1 cm (centimeters), stage II. No dressing. Noted staff has been applying barrier cream to areas liberally. (Resident) is incontinent. Because of location of ulcer, unable to cover with hydrocolloid or Tegaderm absorbent. Reapplied barrier cream...reported to (facility) certified nurse aide of findings, and recommendations. Will call physician to conference..." Signed by home health agency licensed nurse.
11-3-17 at 4:00 pm: New order for RoHo (air-filled, pressure relieving) cushion, labs serum iron level, transferrin level, ferritin level. Continue with buttock cream with petroleum and zinc daily and with brief changes, keep clear and dry. Home health will follow in 1 week per physician." Signed by Licensed Staff C.
11-6-17 at 10:57 am: Documentation of home health wound care nurse visit stated, "Noted new area to left buttocks, unstageable 2.1 x 1.5 x 0.1 cm 50% slough/eschar. Cleansed with wound cleanser. Redressed with Tegaderm absorbent. Right buttocks 2.2 x 1 x 0.1 cm. Redressed with barrier cream. Report given in person to (physician) who agrees with plan of care and agency parameters." Signed by home health agency licensed nurse.
11-6-17 at unknown time: "Physical Therapy/Occupational Therapy evaluate resident for wheelchair cushion and soft mattress. Place

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N046065 | A. BUILDING: _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE GARDENS ASSISTED LIVING | 5201 W 143RD STREET LEAWOOD, KS 66224 |

| (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 |
|---|---|---|---|---|
| S3261 | Continued From page 26 | S3261 | | |

pillow in wheelchair per (physician)." Signed by Licensed Staff C.
11-8-17 at 4:00 pm: "Faxed/called in orders to (home health agency) for physical therapy/occupational therapy for wheelchair cushion and soft mattress." Signed by Licensed Staff B.
11-10-17 at unknown time: Documentation of the home health wound care nurse visit stated, "(Resident) back to bed with moderate assistance. Cleansed wound with wound cleanser. Right buttocks unstageable. Pressure ulcer measures 1.5 x 2.2 x 0.1 cm. Decline. Left buttocks pressure ulcer measures 1.5 x 2.2 x 0.1 cm, unstageable. Decline. No barrier cream available at facility at this time. Covered both areas with bordered foam to protect. Will bring staff Tegaderm absorbent for staff to replace dressings with. Conference call with physical therapist and occupational therapist today. Report is (Resident) has had significant decline in last 6 months and are suggesting hospice. They have discussed with facility staff who will discuss with (physician)" Signed by home health agency licensed nurse.
11-10-17 at 3:00 pm: "New order per (physician) for hospital bed and low air loss mattress, RoHo cushion." Signed by Licensed Staff C.
11-13-17 at unknown time: Documentation of the home health wound care nurse visit stated, "Noted (resident) in bed and soaked with urine...Removed top layer of chux. Noted no dressings on ulcers or buttocks. Left buttocks wound bed without slough. Right buttocks ulcer noted to be softened, slough loosening. Cleansed with wound cleanser. Right 1 x 1.5 x 0.1 cm. Left 1.7 x 1.3 x 0.1 cm. Dressings are not staying in place due to location of ulcers. Will discontinue dressings and return to barrier cream twice and day with pericare or after bowel

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| S3261 | Continued From page 27 | S3261 | | |

movements. Orders written." Signed by home health agency licensed nurse.
11-15-17 at 11:30 am: Resident was discharged from our facility..." Signed by Licensed Staff B.

The record contained documentation by the home health agency nurse's treatment of the resident's wounds but lacked documentation of treatment between home health visits including follow up and ongoing assessments of resident's skin condition by the facility nurse. The record further lacked documentation of date and time wound to buttocks was first noticed by facility staff including steps taken to prevent further impairment.

Interview on 11-28-17 at 4:11 pm with Administrative Nurse A confirmed the resident had open areas on buttocks which were acquired at the facility. Confirmed the record lacked documentation of when the resident's skin first became impaired (including notification of physician and family) and any ongoing assessments by the facility nurse.

For Resident #6, the administrator failed to ensure documentation of initial appearance of impaired skin integrity by facility staff with ongoing assessments of skin and response to treatments.