STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 at the above named assisted living facility conducted on 11-7-16, 11-8-16 and 11-9-16.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c) The facility reported a census of 43 residents. The sample included 3 residents. Based on record review and interview for 1 (#118) of 3 sampled residents, the administrator failed to ensure designated facility staff shall conduct a screening to determine each resident's functional capacity following any significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for resident #118 revealed admission on 6-26-16 with diagnoses Hypertension, Type 2 Diabetes Mellitus, Hyperlipidemia, Anemia, Depression,	S3081		

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

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S3081	Continued From page 1	S3081		

Gastroesophageal Reflux Disease, Merkel Cell Carcinoma of the Scalp and Neck and Malignant Neoplasm of the Pancreas.

The Functional Capacity Screen (FCS) dated 6-23-16 recorded resident required physical assistance with bathing and dressing. Independent with toileting, transfer, walking/mobility, eating and management of medications/treatments. Occasionally incontinent of urine. No problems with cognition. Current problems identified included falls and impaired hearing. The FCS lacked documentation of reassessment following a significant change.

Observation of resident on 11-8-16 at 10:25 am revealed resident #118 resting in hospital bed on low air loss mattress with side rails up on both sides of bed. Resident very thin, with bony prominences. Resident remembered he/she had fallen "5 or 6 weeks ago". Stated, "I'm waiting for my bath." Alert and oriented to person, place and time. Confirmed staff assist with bathing, dressing and all cares. Stated he/she doesn't get out of bed much, but when he/she does, indicated he/she uses a Broda chair (tilt and recline positioning wheelchair) which was stored in the bathroom. Confirmed he/she does not like to be turned and moved much.

Observation on 11-8-16 at 2:00 pm of certified staff H and certified staff J repositioning resident. Resident was reluctant to move due to discomfort. Staff stated it always took two to move resident due to pain/discomfort. Bilateral heels were offloaded. Staff checked resident for incontinence and confirmed resident no longer sits on toilet. Resident also stated he/she does not go into the bathroom to sit on the toilet and that staff check and change him/her every two

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S3081	Continued From page 2 hours. Later observed resident in Broda chair being pushed in common areas by family member. Interview on 11-8-16 at 10:25 am with Licensed Nurse B stated it takes two staff to transfer and turn resident due to pain resident experiences whenever he/she moves. Stated resident is very fragile and currently receives hospice services. Interview on 11-8-16 at 12:57 pm with Licensed Nurse B upon review of FCS dated 6-23-16 stated the FCS should be coded as follows: Unable to perform bathing, dressing, toileting, transfers, walking/mobility and management of medications and treatments; supervision with eating. Stated resident can feed self if staff prepares plate. Stated now has problems with short term memory "gets a little mixed up at times" and memory/recall and decision-making were "somewhat compromised". Further stated resident no longer uses a walker and now uses a Broda chair which was not indicated on the FCS. Confirmed the FCS lacked revision with a change in condition. For resident #118, the administrator failed to ensure the licensed nurse conducted a screening to determine the resident's functional capacity following a significant change in condition as evidenced by inability to transfer, ambulate, bathe and dress self.	S3081		
S3155 SS=D	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	S3155		

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S3155	Continued From page 3 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: KAR 26-41-204(a) The facility reported a census of 43 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#118) of 3 sampled residents, the administrator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of the resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #118 revealed admission on 6-26-16 with diagnoses Hypertension, Type 2 Diabetes Mellitus, Hyperlipidemia, Anemia, Depression, Gastroesophageal Reflux Disease, Merkel Cell Carcinoma of the Scalp and Neck and Malignant Neoplasm of the Pancreas. The Functional Capacity Screen (FCS) dated 6-23-16 recorded resident required physical assistance with bathing and dressing. Independent with toileting, transfer, walking/mobility, eating and management of medications/treatments. Occasionally incontinent of urine. No problems with cognition. Current problem identified included falls and impaired	S3155		

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S3155	Continued From page 4	S3155		

hearing. The FCS lacked documentation of reassessment following a significant change.

The Negotiated Service Agreement (NSA) signed on 10-3-16 recorded services for 2 hour toileting checks (assist to change when soiled) and staff to begin medication management. The NSA lacked documentation of interventions to address resident's fall risk and increased needs.

Observation of resident on 11-8-16 at 10:25 am revealed resident #118 resting in hospital bed on low air loss mattress with side rails up on both sides of bed. Resident very thin, with bony prominences. Resident remembered he/she had fallen "5 or 6 weeks ago". Stated, "I'm waiting for my bath." Alert and oriented to person, place and time. Confirmed staff assist with bathing, dressing and all cares. Stated he/she doesn't get out of bed much, but when he/she does, indicated he/she uses a Broda chair (tilt and recline positioning wheelchair) which was stored in the bathroom. Confirmed he/she does not like to be turned and moved much.

Interview on 11-8-16 at 10:25 am with Licensed Nurse B stated it takes two staff to transfer and turn resident due to pain resident experiences whenever he/she moves. Stated resident is very fragile.

Review of Interdisciplinary Progress Notes:
7-21-16 (no time indicated): "Resident had a fall at approximately 10:30 p.m. A laceration noted on the scalp at the time of assessment. Resident capable of moving both arms and feet. Range of motion strong. Resident stated 'It was slippery and I slipped and fell.' Resident sent to hospital for evaluation at 2:30 A.M...." Signed by Licensed Nurse C.

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S3155	Continued From page 5 8-15-16 at 11:45 am: "During discussion, resident advised nurse that he/she fell in room yesterday and has some sore places..." Signed by Licensed Nurse D. 9-14-16 (no time indicated): "Resident fell at 4:15 a.m. on the way back from bathroom, no injury, will continue to monitor." Signed by Licensed Nurse E. 9-14-16 at 7:30 am: "Late Entry: Resident fell again around 7:20 am, this nurse observed resident lying on left side with walker tipped over to its side. Resident stated he/she was heading to the bathroom. Resident complained of left hip and leg pain, resident refused nurse to call 911 for assistance. Staff assisted resident to bed, resident refused to be sent over to hospital for evaluation.." Signed by Licensed Nurse F. Interview on 11-8-16 at 1:00 pm with Licensed Nurse B confirmed the Negotiated Service Agreement lacked documentation of a health care service plan including interventions to address resident's fall risk, interventions to address resident's risk for skin impairment due to immobility and documentation of hospice services, which included bathing by hospice staff. For resident #118, the administrator failed to ensure the licensed nurse provided or coordinated the provision of health care services to address resident's fall risk, risk for skin impairment and use of hospice services.	S3155		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and	S3165		

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S3165	Continued From page 6 supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 43 residents. The sample included 3 residents. For all residents the operator failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health care services plan as evidenced by record review and interview for 3 (#118, #119, #120) of 3 sampled residents. Findings included: - Record review for resident #118 revealed admission on 6-26-16 with diagnoses Hypertension, Type 2 Diabetes Mellitus, Hyperlipidemia, Anemia, Depression, Gastroesophageal Reflux Disease, Merkel Cell Carcinoma of the Scalp and Neck and Malignant Neoplasm of the Pancreas. The Functional Capacity Screen dated 6-23-16 recorded resident required health care services. The Negotiated Service Agreement (NSA) signed on 10-3-16 recorded services for 2 hour toileting checks (assist to change when soiled) and staff to begin medication management. The NSA failed to designate the licensed nurse responsible for the implementation and supervision of health care services. - Record review for resident #119 revealed admission on 10-28-16 with diagnoses Dementia	S3165		

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S3165	Continued From page 7	S3165		

and Glaucoma. The Functional Capacity Screen dated 9-26-16 recorded resident required health care services.

The Negotiated Service Agreement dated 10-31-16 recorded services for staff assistance with bathing, dressing, and administration of medication. The NSA failed to designate the licensed nurse responsible for the implementation and supervision of health care services.

- Record review for resident #120 revealed admission on 3-24-15 with diagnoses Insulin Dependent Diabetes Mellitus, Gastroesophageal Reflux Disease, Renal Failure, Hypertension, Hyperlipidemia, and Hypertension. The Functional Capacity Screen dated 9-28-16 recorded resident required health care services.

The Negotiated Service Agreement (NSA) dated 5-20-16 recorded services for staff assistance with bathing, dressing, and toileting. The NSA failed to designate the licensed nurse responsible for the implementation and supervision of health care services.

Interview on 11-8-16 at 1:00 pm with Licensed Nurse B stated he/she was currently the nurse responsible for the health care service plans. Confirmed the Negotiated Service Agreements lacked the name of the nurse responsible for the plans.

For all residents, the administrator failed to ensure the negotiated service agreement contained the name
of the licensed nurse responsible for the implementation and supervision of the health care services plan.

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S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 43 residents. The sample included 3 residents. Based on record review and interview for 1 (#118) of 3 sampled residents, the administrator failed to ensure documentation of all incidents and indications of illness or injury including the date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #118 revealed admission on 6-26-16 with diagnoses Hypertension, Type 2 Diabetes Mellitus, Hyperlipidemia, Anemia, Depression, Gastroesophageal Reflux Disease, Merkel Cell Carcinoma of the Scalp and Neck and Malignant Neoplasm of the Pancreas. The Functional Capacity Screen (FCS) dated 6-23-16 recorded resident required physical assistance with bathing and dressing. Independent with toileting, transfer, walking/mobility, eating and management of medications/treatments. Occasionally incontinent	S3261		

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S3261	Continued From page 9	S3261		

of urine. No problems with cognition. Current problem identified included falls and impaired hearing. The FCS lacked documentation of reassessment following a significant change.

The Negotiated Service Agreement (NSA) signed on 10-3-16 recorded services for 2 hour toileting checks (assist to change when soiled) and staff to begin medication management. The NSA lacked documentation of interventions to address resident's fall risk and increased needs.

Review of Interdisciplinary Progress Notes:
8-15-16 at 11:45 am: "During discussion, resident advised nurse that he/she fell in room yesterday and has some sore places. Discussed with resident if he/she continues to have pain to notify staff." Signed by Licensed Nurse D.
The entry lacked documentation of assessment by a licensed nurse, any action taken and results of the action.

9-14-16 (no time indicated): "Resident fell at 4:15 a.m. on the way back from bathroom, no injury, will continue to monitor." Signed by Licensed Nurse E.
The entry lacked documentation of assessment by a licensed nurse, any action taken and results of the action.

9-14-16 at 7:30 am: "Late Entry: Resident fell again around 7:20 am, this nurse observed resident lying on left side with walker tipped over to its side. Resident stated he/she was heading to the bathroom. Resident complained of left hip and leg pain, resident refused nurse to call 911 for assistance. Staff assisted resident to bed, resident refused to be sent over to hospital for evaluation.." Signed by Licensed Nurse F.
The record lacked documentation of a complete

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S3261	Continued From page 10 nurse's assessment and notification of the physician. 9-25-16 at 10:11 am: "CMA (Certified Medication Aide) advised that resident complained of pain, burning upon urination and had stated he/she believes he/she has a urinary tract infection. Call placed to hospice. awaiting return call. Signed by unknown staff. 9-25-16 at 10:28 am: "Return call from hospice resident has nursing visit scheduled for tomorrow. Will place call to primary physician and advise if on call returns call and addresses issue today will all back, otherwise will be handled during that visit." Signed by unknown staff. The record lacked documentation of assessment by a licensed nurse, any further follow up (action taken) and results of the action. Interview on 11-8-16 at 1:14 pm with Licensed Nurse B upon review of the notes confirmed the above notes lacked documentation of assessment by a licensed nurse, and follow up including actions taken. For resident #118, the administrator failed to ensure the record contained documentation of assessments by a licensed nurse following falls or indications of illness including follow up (actions taken).	S3261		