STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105014	A. BUILDING: _____ B. WING _____	10/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HIGHLANDS ASSISTED LIVING	12600 DELAWARE PARKWAY KANSAS CITY, KS 66109

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey at the above named assisted living facility conducted on 10-10-16 and 10-11-16.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(A) The facility reported a census of 117 residents. The sample included 6 residents and one closed	S 135		

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

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S 135	Continued From page 1	S 135		

record review. For 1 (#3) of 6 sampled residents, the administrator failed to ensure that designated facility staff consulted with the resident's physician upon occurrence of an accident involving the resident that resulted in injury and had the potential for requiring a physician's intervention.

Findings included:

- Record review for resident #3 revealed admission on 7-8-12 with diagnoses Urothelial Carcinoma, Brain Mass, Seizure Disorder, Depression, Pill Rolling Tremors, Recurrent Urinary Tract Infections, and Mild Congestive Heart Failure.

The Functional Capacity Screen dated 7-9-16 recorded resident unable to perform management of medications/treatments. No problems with cognition. The FCS lacked documentation that indicated resident was a fall risk.

The Negotiated Service Agreement/Health Care Service Plan dated 7-9-16 recorded services for physical assistance with management of medications. and total assist with treatments. Resident receiving physical and occupational therapy per home health agency. The NSA/HCSP stated resident had falls on 6-15-16 and 8-29-16 and had been instructed to wear non-skid footwear. The NSA/HCSP lacked further interventions to address resident's fall risk and an additional fall on 9-21-16.

Nursing Progress Notes stated:

9-1-16 at 2:00 p.m.: "Resident informed this writer that he/she fell and bumped his/her head on 8-29-16 and has been having headaches

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S 135	Continued From page 2	S 135		

since then and hasn't been able to eat much and has been having vertigo. Resident stated he/she wanted to go to the hospital via 911, the EMS (emergency medical service) was called to transport resident to (hospital) for evaluation and treatment post head trauma. Will continue to monitor." Signed by licensed staff B. The record lacked documentation of the fall on 8-29-16. (Note: resident admitted to hospital. Diagnosis unknown. Returned to facility on 9-20-16).

9-21-16 at 7:10 p.m.: Resident pushed pendant. Reports that he/she fell in bedroom and hit back of head. Resident reports that he/she feels dizzy and requests to go to (hospital) emergency room for evaluation. Blood Pressure 100/82, Pulse 80, Respirations 20, Temperature 98.0. Resident's (family member) was notified. Resident has no visible injuries taken by EMS to (hospital)." Signed by licensed staff C.
(Note: resident admitted with diagnosis: Urinary Tract Infection and Severe Sepsis).

The record lacked documentation of notification of the primary care provider of falls on 8-29-16 and 9-21-16 along with complaints of vertigo and dizziness after hitting his/her head with each fall.

Interview on 10-10-16 at 3:35 p.m. with the licensed staff C confirmed the physician had not been notified about the falls and complaints of vertigo/dizziness.

For resident #3, the administrator failed to ensure that designated facility staff consulted with the resident's primary care physician after he/she experienced falls with possible head injury.

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S3028	Continued From page 3	S3028		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3) The facility reported a census of 117 residents. The sample included 6 residents and one closed record review. Based on record review and	S3028		

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S3028	Continued From page 4 interview for 1 (#6) of 6 sampled residents, the administrator failed to ensure each allegation of abuse shall be reported to the department within 24 hours. Findings included: - Record review for resident #6 revealed admission on 7-4-12 with diagnoses Diabetes Mellitus, Atrial Fibrillation, Osteoarthritis, Dyslipidemia, Gastroesophageal Reflux Disorder, Restless Leg Syndrome, and Obstructive Sleep Apnea. The Functional Capacity Screen (FCS) dated 6-19-16 recorded resident required health care services. The negotiated service agreement/health care service plan (NSA/HCSP) dated 6-19-16 recorded services for assistance with bathing and treatments. Interview on 10-10-16 at 10:10 a.m. with licensed staff A stated resident #6 "was getting too friendly with another resident and it was unwanted. Stated the administrator spoke with resident #6 and gave the resident a "warning letter" dated 1-13-16. Licensed staff A was unsure whether this was reported by the administrator to the department. Licensed staff A provided a copy of the warning letter which stated: "Recently two residents have spoken to me regarding inappropriate comments or actions that you have initiated with them. One of the individuals stated you asked him/her "what would you do if I put my hands between your legs." The second individual states you came into his/her room and placed your power scooter in such a position that he/she could not walk past you or his/her furniture ...you	S3028		

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S3028	Continued From page 5 also pulled his/her head down and began kissing him/her and attempted to put your tongue in his/her mouth. On both occasions these actions were initiated by you without requesting permission ...These actions are totally unacceptable. This letter serves as a written warning that should any of these types of actions occur again with any resident...you will be given a 30 day notice of discharge." Interview via phone with administrator on 10-10-16 at 3:55 p.m. regarding whether incidents with resident #6 was reported to the department, stated "I really don't believe I did, but probably should have" and confirmed the incident was not reported. For resident #6, the administrator failed to ensure an allegation of abuse was reported to the department.	S3028		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route.	S3200		

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S3200	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 117 residents. The sample included 6 residents and one closed record review. Based on record review and interview for 1(#2) of 5 sampled residents whose medications are managed and administered by the facility, the administrator failed to ensure that all medications and biologicals are administered in accordance with a medical care provider's written order and professional standards of practice when the resident failed to receive insulin as ordered. Findings included: - Record review for resident #2 revealed admission on 12-3-15 with diagnoses Type 2 Diabetes Mellitus, Obesity, Bipolar Disorder, Chronic Pain, Hypothyroidism, Hyperlipidemia and Stress Incontinence. The Functional Capacity Screen (FCS) dated 2-10-16 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 2-10-16 recorded services for physical assistance with management of medications, requires staff to do daily accuchecks (blood glucose monitoring) and insulin injections. Total staff assistance for treatments. Review of Medication Administration Record for	S3200		

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S3200	Continued From page 7 September 2016 revealed record lacked documentation of administration of Novolog Flexpen (per sliding scale in addition to scheduled insulin)) on the following dates/times: 9-2-16 at 5:00 p.m.; 9-2-16 and 9-3-16 at bedtime; 9-11-16 at 8:00 a.m.; 9-11-16 at 12:00 p.m.; 9-12-16 at 8:00 a.m. and 12:00 p.m.; 9-16-16 at 8:00 a.m.; 9-26-16 and 9-28-16 at 8:00 a.m. (Note: no blood sugars documented on these dates/times as ordered). For Toujeo Solostar insulin (Inject 102 units subcutaneously daily), the record lacked documentation of administration on the following dates/times: 9-12-16 and 9-28-16 at 8:00 a.m. For Novolog Flexpen (Inject 35 units subcutaneously three times a day), the record lacked documentation of administration on the following dates/times: 9-2-16 at 5:00 p.m.; 9-11-16 and 9-12-16 at 12:00 p.m. Interview on 10-10-16 at 3:45 p.m. with licensed staff B stated licensed nurses administer all insulin. Stated residents who receive insulin are supposed to come to the nurse's office when it's time. Regarding resident #2, stated "sometimes we can run him/her down, but can't always find him/her." Reviewed Medication Administration records and confirmed on the above dates/times the resident failed to receive insulin as ordered by the physician. Licensed staff B was unable to state why resident did not receive the insulin when no reason was documented (by him/herself) and confirmed the physician was not notified when resident failed to receive insulin as ordered.	S3200		

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S3200	Continued From page 8 For resident #2, the administrator failed to ensure that all medications and biologicals are administered in accordance with a medical care provider's written order and professional standards of practice when the resident failed to receive insulin as ordered.	S3200		