

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N105014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER DELAWARE HIGHLANDS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 DELAWARE PARKWAY KANSAS CITY, KS 66109		
(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 the licensure resurvey with attached complaint number's 174034, 173725, 173697, 173567, 172916, 172672, 170747, 170613, 169340, 169089, 164132, 161523 for the above named facility conducted on 08/16/22 and 08/17/22.	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: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 102 residents. The sample included 6 residents (R) and two closed record reviews. Based on record review and interview the administrator failed to protect R172 from neglect when the facility staff failed to place fall interventions and follow up on physician progress notes. This resulted in R172 being sent to the hospital in June for emergency evaluation and in July a hospitalization which required a stay in a rehabilitation prior to readmission to the facility. The resident was back at the facility for 18 days when he was again	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 taken by emergency medical transport back to the hospital. The hospital discharge orders dated 07/12/22 identified the need for physical therapy and home health nursing. The resident record lacked an updated "Functional Capacity Screen" identifying the current functional capacity of the resident. The resident "Negotiated Service Agreement" lacked the identification of physical therapy or home health, and other healthcare services the resident would have required based on the "FCS". The resident returned to the hospital on 7/31/2022. Findings included: - Record review for R172 revealed an admission date of 01/09/20 with diagnoses of hypertension, mood disorder, dementia, chronic obstructive pulmonary disease, chronic kidney disease, unsteady gait, muscle weakness and presence of colostomy. Record review of the "FCS" (Functional Capacity Screen) dated 10/01/21 identified R712 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He required supervision with his medications, he was occasionally incontinent, and his cognition was intact. He was understandable and had the ability to understand others. He was marked as a fall risk and used a walker assistive device. Record review of the combined "NSA/HSP" (Negotiated Service Agreement/Healthcare Service Plan) dated 10/01/21 identified / instructed staff to provide the following healthcare services; he was independent with all activities of daily living, ambulation, and care of	S3026		

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S3026	Continued From page 2 the ostomy. His judgement and memory were good. Record review of the facility document titled "Negotiated Service Agreement Addendum" included the following Fall / Safety; Resident will keep pendent within reach at all times. If observed without, facility staff will offer reminders and home health for physical therapy. Signed by R712 on 11/03/21. Record review of R172 "Nursing Progress Notes" and Primary Care Physician notes revealed the following entries; 11/02/21 at 08:45 AM - Resident found on floor in apartment by kitchen staff when delivering room tray. Nursing staff notified. Maintenance manager assisted in locating pendant resident placed pendent in a box. Pendant placed around residents' neck. Resident has no complaints of pain or discomfort noted at this time. Called family and no numbers were available Resident stated that he slid off the side of his bed. "Resident educated on importance of wearing pendant at all times". "Progress Note"/ Primary Care Physician notes date 01/27/22 - Identified resident to have a diagnosis of major depressive disorder in partial remission. In house psychiatry following. R172 "NSA" lacked documentation of facility provided psychiatry services. "Progress Note"/ Primary Care Physician notes dated 06/14/22 - Resident was ambulating with a	S3026		

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S3026	Continued From page 3 walker. During this visit he reported that he was becoming more forgetful and had difficulty with finding words when he was trying to say something. 06/22/22 at 12:00 PM - "Notified by other staff that resident found on the floor near closet with his walker located in living room". Resident does not recall how he ended up there. Resident is alert and oriented times three but hitting head could not be ruled out. Resident willing to be evaluated by emergency room. Resident was transported to hospital by emergency medical services. 06/24/22 05:00 PM- Resident back around 04:50 PM calm and pleasant. denied pain, no complaints. 06/28/22 at 11:00 AM - Resident alerted staff via his call light. Resident found on floor in bathroom. He was alert and oriented times three. He stated he lost his balance while changing ostomy bag. Denies hitting head. Complaint of pain in left leg/hip with limited range of motion or ability to sit or stand. Resident requested emergency medical services transport to hospital. "Physician Order" dated 07/12/22 - discharge home on 07/14/22 with current medications, home health, physical therapy and occupational therapy to evaluate and treat. 07/14/22 at 01:00 PM - Resident returned from rehabilitation. Will have next shift on complete return assessment.	S3026		

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S3026	Continued From page 4 "Progress Note"/ Primary Care Physician dated 07/19/22 - stated resident uses a walker for mobility fall and safety precaution; monitor. 07/29/ (no year recorded) at 02:30 AM - Resident attempted to get out of bed to take off extra layers of clothing. Resident stated when he stood up he felt weak and slid himself to the floor with the side of his bed. No injuries noted. The record lacked an intervention. 07/31/22 (no time recorded) - Resident found sitting in recliner. Resident has decreased alertness, increased weakness and unable to stand. Resident transported to hospital for evaluation. Record review of the progress notes provided by the hospital signed on 07/31/22 revealed the resident was hospitalized the end of June and in early July 2022 for recurrent falls, weakness and weight loss. As of 08/18/2022 resident remained in the hospital. The "Nursing Progress Notes" lacked the follow up charting for all incidents, symptoms, and other indications of illness of injury including the date, time of occurrence, action taken, and results of the actions. The record lacked alert charting for seventy-two hours after returning to the facility from a rehabilitation facility. On 08/17/22 Interview with Director of Nursing A and Assistant Director of Nursing B revealed R172 remained in the hospital. They confirmed R172 records lacked the "FCS" being performed	S3026		

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S3026	Continued From page 5 when the resident exhibited a significant change, and the "NSA" lacked the required interventions/healthcare services the resident would have required based on the "FCS" results showing the significant change. The administrator failed to protect R172 from neglect when the facility staff failed to place fall interventions and follow up on physician progress notes. This resulted in R172 being sent to the hospital for emergency evaluation and in July a hospitalization which required a stay in a rehabilitation unit prior to coming back to the assisted living facility. He was in the assisted living facility for 18 days when he was sent by emergency medical transport back to the hospital. The discharge orders identified the need for physical therapy and home health nursing. The resident record lacked an updated "Functional Capacity Screen" identifying the current functional capacity of the resident. The resident "Negotiated Service Agreement" lacked the identification of physical therapy or home health, and other healthcare services the resident would have required based on the "FCS". The resident returned to the hospital on 7/31/2022 where he remained on 08/17/22.	S3026		
S3081 SS=E	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	S3081		

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S3081	Continued From page 6 (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)(1)(2) The facility reported a census of 102 residents with six residents included in the sample and two for closed record review. Based on interview and record review the administrator failed to complete a "Functional Capacity Screen" (FCS) for Resident (R) 814 and R172 following a significant change in condition and for R813 at least once every 365 days. Findings included: - Record review for R814 revealed an admission date of 07/08/19 with the following diagnoses: acute and chronic respiratory failure with hypoxia, congestive heart failure, type two diabetes mellitus, and malnutrition. The 02/10/22 Annual "FCS" identified R814 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications and treatments. She was occasionally incontinent of bladder and was marked for falls and impaired vision. The 02/10/22 combined Annual "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide minimal assistance twice weekly for bathing,	S3081		

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S3081	Continued From page 7 minimal assistance for dressing and toileting, stand-by assistance as R814 directed for transfers, she propelled herself in her wheelchair but may need assistance for long distances; assistance with opening packages and directions for eating, physical assistance with management of medications, oxygen per nasal cannula for treatments, and assistance with toileting. Staff were to instruct R814 to remain seated and call for assistance if she felt weak or dizzy to prevent falls. The 06/29/22 03:30 PM "Nursing Progress Note" documented R814 was sent to the hospital for "overall weakness, low vitals, and unable to toilet herself." The 07/23/22 01:00 PM "Nursing Progress Note" documented R814 returned to the facility. This was the last nurse's note documented for R814. The next page of the "Nursing Progress Notes" blank except an attached sticky note read "114 fell @ 2:15 AM called 911 for assist!" R814's record lacked documentation of a Significant Change "FCS" completed after her return from the hospital on 07/23/22 to the facility. - Record review for R813 revealed an admission date of 06/01/19 with the following diagnoses: unsteady gait, syncope, major depressive disorder, unsteady gait, and history of fall. The 07/08/21 most recent "FCS" identified R813 required physical assistance with bathing, dressing, toileting, and management of medications and was marked for falls.	S3081		

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S3081	Continued From page 8 The 07/08/21 most recent combined Annual "NSA/HSP" identified facility staff would provide minimal assistance daily for bathing, minimal assistance for dressing, moderate assistance for toileting, physical assistance for management of medications, and instruct R813 to wear non-skid footwear, keep her pathway lighted and free of obstacles, and keep assistive devices within reach to prevent falls. On 08/16/22 R813's record lacked an annual FCS within 365 days, which was 39 days late. On 08/16/22 at 01:25 PM Administrative Nurse B confirmed R814's 02/10/22 FCS was the most recent since a significant change FCS had not been completed and R813's 07/08/21 FCS was the most recent. The administrator failed to complete an "FCS" for R814 following a significant change in condition and for R813 at least once every 365 days. - Record review for R212 revealed an admission date of 09/30/2019 with diagnoses of hypertension, mood disorder, hearing loss, dementia, chronic obstructive pulmonary disease, unsteady gait, major depressive disorder, muscle weakness, colostomy present. Record review on of the "FCS" dated 09/07/21 identified the resident required physical assistance with bathing and medication management. He required supervision with dressing, and he was independent with toileting, transferring, walking and eating. He was continent of bladder, his cognition was intact, he	S3081		

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S3081	Continued From page 9 could make himself understood and he usually understood others. He was marked with impaired hearing and used no mobility device. Record review on of the combined "NSA/HSP" identified the following services provided and instructions to staff; Facility staff were to provide minimal assist with bathing, he was independent with dressing, continent of bowel and bladder, and independent with ostomy. He was independent with transfers, and eating, and required an escort to most meals and activities. He was marked with impaired judgement / memory and needed occasional monitoring/ guidance / redirection. Facility staff will offer reminders/ cues when necessary. Facility staff to manage resident mediations. Record review of the "Nursing Progress Notes" and primary care physician "Progress notes" revealed the following entries; 04/03/22 a 02:00 PM - Resident continued on antibiotic treatment. He ambulated with a roller walker with stand by assist. Noted to have been dragging his right leg, he needed verbal cues to pick it up. Denies any pain. 04/03/22 at 11:00 PM - Resident alert and oriented times one. He was unable to voice concerns. He was lethargic, and he denied pain. Resident was slow to answer questions. Emergency medical services called for altered mental status. 05/02/22 at 03:30PM - Resident arrived from rehabilitation facility. Uses a walker to ambulate. Resident now has a leg catheter and colostomy	S3081		

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S3081	Continued From page 10 bag. Home health will be contacted for management. "Progress Note"/ Primary Care Physician Note dated 05/05/22 - Resident being seen for a follow up after his recent hospitalization. He was sent to hospital on 04/03/22. He was to have physical therapy, occupational therapy, speech therapy and skilled nursing. The functional status indicated he was dependent on a walker. 05/10/2022 at 09:30 PM - Resident had increased confusion and had been dragging his catheter bag, pulling on the tubing and there was blood in the catheter. "Progress Note"/ Primary Care Physician Note dated 05/10/22 - Nurse reported that resident had blood in his Foley catheter bag. During the visit the resident sat in the chair with the Foley catheter bag on the floor next to him. He appears very confused and nurse reported that he has been dragging his catheter bag when he walks around. "Progress Note"/ Primary Care Physician Note dated 05/19/22 - diagnoses of other abnormalities of gait and mobility. "Progress Note" / Primary Care Physician Note dated 06/14/22 - indwelling Foley catheter present. Cognitive status; dementia. Gait instability; fall / safety precaution. 06/21/22 at 07:00 PM - resident trying to change is own colostomy bag. 08/03/22 at 09:00 PM - resident transferred to	S3081		

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S3081	Continued From page 11 hospital for catheter, inflammation/pain. 08/03/22 at 11:00 PM - resident returned to the facility by his grandson. Observation on 08/16/2022 during the noon time meal; resident sat at the end of the table with a staff member, a red walker was sitting next to his chair. After the resident ate his lunch he walked with the staff member out of the dining room. Interview on 08/17/22 with "Director of nursing" A and Assistant director of nursing B revealed the resident record lacked an updated "FCS" and "NSA/HSP" identifying the resident required a walker/mobility device and had an indwelling urinary catheter. On 08/17/22 Interview with Director of Nursing A and Assistant Director of Nursing B revealed R212 records lacked the "FCS" being performed when the resident exhibited a significant change, and the "NSA" lacked the required interventions/healthcare services the resident would have required based on the "FCS" results showing the significant change. - Record review for R172 revealed an admission date of 01/09/20 with diagnoses of hypertension, mood disorder, dementia, chronic obstructive pulmonary disease, chronic kidney disease, unsteady gait, muscle weakness and presence of colostomy. Record review of the "FCS" (Functional Capacity Screen) dated 10/01/21 identified R172 was independent with bathing, dressing, toileting,	S3081		

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S3081	Continued From page 12 transferring, walking/mobility, and eating. He required supervision with his medications, he was occasionally incontinent, and his cognition was intact. He was understandable and had the ability to understand others. He was marked as a fall risk and used a walker/assistive device. Record review of the combined "NSA/HSP" (Negotiated Service Agreement/Healthcare Service Plan) dated 10/01/21 identified / instructed staff to provide the following healthcare services; he was independent with all activities of daily living, ambulation, and care of the ostomy. His judgement and memory were good. Record review of the facility document titled "Negotiated Service Agreement Addendum" included the following: Fall / Safety; Resident will keep pendent within reach at all times. If observed without, facility staff will offer reminders and home health for physical therapy. Signed by R712 on 11/03/21. Record review of R172 "Nursing Progress Notes" and Primary Care Physician notes revealed the following entries; 11/02/21 at 08:45 AM - Resident found on floor in apartment by kitchen staff when delivering room tray. Nursing staff notified. Maintenance manager assisted in locating pendant resident placed pendent in a box. Pendant placed around residents' neck. Resident has no complaints of pain or discomfort noted at this time. Called family and no numbers were available Resident stated that he slid off the side of his bed. "Resident educated on importance of wearing	S3081		

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S3081	Continued From page 13 pendant at all times". "Progress Note"/ Primary Care Physician notes date 01/27/22 - Identified resident to have a diagnosis of major depressive disorder in partial remission. In house psychiatry following. R172 "NSA" lacked documentation of facility provided psychiatry services. "Progress Note"/ Primary Care Physician notes dated 06/14/22 - Resident was ambulating with a walker. During this visit he reported that he was becoming more forgetful and had difficulty with finding words when he was trying to say something. 06/22/22 at 12:00 PM - "Notified by other staff that resident found on the floor near closet with his walker located in living room". Resident does not recall how he ended up there. Resident is alert and oriented times three but hitting head could not be ruled out. Resident willing to be evaluated by emergency room. Resident was transported to hospital by emergency medical services. 06/24/22 05:00 PM- Resident back around 04:50 PM calm and pleasant. denied pain, no complaints. 06/28/22 at 11:00 AM - Resident alerted staff via his call light. Resident found on floor in bathroom. He was alert and oriented times three. He stated he lost his balance while changing ostomy bag. Denies hitting head. Complaint of pain in left leg/hip with limited range of motion or	S3081		

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NAME OF PROVIDER OR SUPPLIER DELAWARE HIGHLANDS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 DELAWARE PARKWAY KANSAS CITY, KS 66109		
(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
S3081	Continued From page 14 ability to sit or stand. Resident requested emergency medical services transport to hospital. "Physician Order" dated 07/12/22 - discharge home on 07/14/22 with current medications, home health, physical therapy and occupational therapy to evaluate and treat. 07/14/22 at 01:00 PM - Resident returned from rehabilitation. Will have next shift on complete return assessment. "Progress Note"/ Primary Care Physician dated 07/19/22 - stated resident uses a walker for mobility fall and safety precaution; monitor. 07/29/ (no year recorded) at 02:30 AM - Resident attempted to get out of bed to take off extra layers of clothing. Resident stated when he stood up he felt weak and slid himself to the floor with the side of his bed. No injuries noted. The record lacked an intervention for the incident. 07/31/22 (no time recorded) - Resident found sitting in recliner. Resident has decreased alertness, increased weakness and unable to stand. Resident transported to hospital for evaluation. Record review on 08/16/22 of the progress notes provided by the hospital signed on 07/31/22 revealed the resident was hospitalized the end of June and again in early July 2022 for recurrent falls, weakness and weight loss. As of 08/18/2022 resident remained in the hospital.	S3081		

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S3081	Continued From page 15 The "Nursing Progress Notes" lacked the follow up charting for all incidents, symptoms, and other indications of illness of injury including the date, time of occurrence, action taken, and results of the actions. The record lacked alert charting for seventy-two hours after returning to the facility from a rehabilitation facility that was to be done per the nursing progress note entry. On 08/17/22 Interview with Director of Nursing A and Assistant Director of Nursing B revealed R172 remained in the hospital. They confirmed R172 records lacked the "FCS" being performed when the resident exhibited a significant change, and the "NSA" lacked the required interventions/healthcare services the resident would have required based on the "FCS" results showing the significant change. The administrator failed to complete a "Functional Capacity Screen" (FCS) for Resident (R) 814 and R172 following a significant change in condition and for R813 at least once every 365 days.	S3081		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The	S3085		

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S3085	Continued From page 16 negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a) The facility reported a census of 102 residents with six residents sampled and two residents chosen for closed record reviews. Based on interview and record review the administrator failed to ensure Resident (R) 810, and R812's "Negotiated Service Agreements" (NSA) described the services each resident would receive based on their "Functional Capacity Screens" (FCS). This failure put the residents at risk for injury and of receiving inappropriate care by facility staff. Findings included: - Record review for R810 revealed an admission date of 07/08/19 with the following diagnoses: anxiety, depression, dementia, and congestive heart failure. The 12/23/21 annual "FCS" identified R810 required supervision with bathing and dressing, physical assistance with management of medications, and was frequently incontinent of	S3085		

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S3085	Continued From page 17 bladder. She was independent with toileting, transfers, walking/mobility, and eating. She was not marked for short-term or long-term memory, memory/recall, or decision-making difficulties and was understandable and understands others with communication. The 12/23/21combined "NSA/HCP" directed facility staff to provide cueing for bathing, she was independent with dressing, toileting, transfers, walking/mobility, and eating, physical assistance for management of medications, and nursing staff to adjust her bladder stimulator as she directed and to notify her physician of increased urinary discomfort. Staff were to provide occasional monitoring, guidance, redirection, and she could go on supervised outings only for cognition. The "NSA/HCP" directed facility staff that R810 was independent with dressing while her "FCS" identified she required supervision. Her "NSA/HCP" directed facility staff to provide occasional monitoring, guidance, redirection, and she could go on supervised outings only while her FCS identified she did not have cognitive difficulties. - Record review for R812 revealed an admission date of 04/01/21 with the following diagnoses: anxiety, major depressive disorder, dementia, chronic low back pain, unsteady gait, and dysphagia. The 03/30/22 annual "FCS" identified R812 required supervision for bathing and dressing, physical assistance for management of medications, was independent with toileting,	S3085		

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S3085	Continued From page 18 transfers, walking/mobility, eating, and was occasionally incontinent of bladder. She was not marked for short-term or long-term memory, memory/recall, or decision-making difficulties, was understandable and understands others with communication, and was not marked for wandering. The 03/30/22 combined "NSA/HCP" directed facility staff to provide cueing twice weekly for bathing and twice daily for dressing, physical assistance with management of medications, and occasional monitoring, guidance, redirection, safety checks four times daily, with no safety checks at night for cognition. The "NSA/HCP" directed facility staff to provide occasional monitoring, guidance, redirection, safety checks four times daily while her FCS identified she did not have cognitive difficulties and to observe for changes of condition, periods of agitation, or "needing to go home" for wandering while her "FCS" identified she did not exhibit wandering behavior. On 08/17/22 at approximately 12:54 PM Administrative Staff A stated R810 was able to dress herself independently. She expected the "NSA" to match each resident's "FCS." The administrator failed to ensure R810, and R812's NSA described the services each resident would receive based on their FCS.	S3085		
S3092 SS=F	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure	S3092		

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S3092	Continued From page 19 the review and, if necessary, revision of each negotiated service agreement 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; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (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. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-202 (d) (2) The facility reported a census of 102 residents. The sample included 6 residents (R) and 2 closed record reviews. Based on observation, record review and interview the administrator failed to ensure the licensed nurse reviewed and if necessary revised the negotiated service agreements for R172 and R212 to reflect the necessary healthcare services after a change of condition. Findings included: - Record review for R172 revealed an admission date of 01/09/20 with diagnoses of hypertension, mood disorder, dementia, chronic obstructive pulmonary disease, chronic kidney disease, unsteady gait, muscle weakness and presence of	S3092		

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S3092	Continued From page 20 colostomy. Record review of the "FCS" (Functional Capacity Screen) dated 10/01/21 identified R172 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He required supervision with his medications, he was occasionally incontinent, and his cognition was intact. He was understandable and had the ability to understand others. He was marked as a fall risk and used a walker assistive device. Record review of the combined "NSA/HSP" (Negotiated Service Agreement/Healthcare Service Plan) dated 10/01/21 identified / instructed staff to provide the following healthcare services; he was independent with all activities of daily living, ambulation, and care of the ostomy. His judgement and memory were good. Record review of the facility document titled "Negotiated Service Agreement Addendum" included the following Fall / Safety; Resident will keep pendent within reach at all times. If observed without, facility staff will offer reminders and home health for physical therapy. Signed by R712 on 11/03/21. Record review of R172 "Nursing Progress Notes" and Primary Care Physician notes revealed the following entries; 11/02/21 at 08:45 AM - Resident found on floor in apartment by kitchen staff when delivering room tray. Nursing staff notified. Maintenance manager assisted in locating pendant, resident placed	S3092		

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S3092	Continued From page 21 pendent in a box. Pendant placed around resident's neck. Resident has no complaints of pain or discomfort noted at this time. Called family and no numbers were available Resident stated that he slid off the side of his bed. "Resident educated on importance of wearing pendant at all times". "Progress Note"/ Primary Care Physician notes dated 01/27/22 - Identified resident to have a diagnosis of major depressive disorder in partial remission. In house psychiatry following. R172 "NSA" lacked documentation of facility provided psychiatry services. "Progress Note"/ Primary Care Physician notes dated 06/14/22 - Resident was ambulating with a walker. During this visit he reported that he was becoming more forgetful and had difficulty with finding words when he was trying to say something. 06/22/22 at 12:00 PM - "Notified by other staff that resident found on the floor near closet with his walker located in living room". Resident does not recall how he ended up there. Resident is alert and oriented times three but hitting head could not be ruled out. Resident willing to be evaluated by emergency room. Resident was transported to hospital by emergency medical services. 06/24/22 05:00 PM- Resident back around 04:50 PM calm and pleasant. Denied pain, no complaints.	S3092		

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S3092	Continued From page 22 06/28/22 at 11:00 AM - Resident alerted staff via his call light. Resident found on floor in bathroom. He was alert and oriented times three. He stated he lost his balance while changing ostomy bag. Denies hitting head. Complaint of pain in left leg/hip with limited range of motion or ability to sit or stand. Resident requested emergency medical services transport to hospital. "Physician Order" dated 07/12/22 - discharge home on 07/14/22 with current medications, home health, physical therapy and occupational therapy to evaluate and treat. 07/14/22 at 01:00 PM - Resident returned from rehabilitation. Will have next shift on complete return assessment. "Progress Note"/ Primary Care Physician dated 07/19/22 - stated resident uses a walker for mobility fall and safety precaution; monitor. 07/29/ (no year recorded) at 02:30 AM - Resident attempted to get out of bed to take off extra layers of clothing. Resident stated when he stood up he felt weak and slid himself to the floor with the side of his bed. No injuries noted. The record lacked an intervention for the incident. 07/31/22 (no time recorded) - Resident found sitting in recliner. Resident has decreased alertness, increased weakness and unable to stand. Resident transported to hospital for evaluation.	S3092		

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S3092	Continued From page 23 Record review of the progress notes provided by the hospital signed on 07/31/22 revealed the resident was hospitalized the end of June and in early July 2022 for recurrent falls, weakness and weight loss. As of 08/18/2022 resident remained in the hospital. The "Nursing Progress Notes" lacked the follow up charting for all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions. The record lacked alert charting for seventy-two hours after returning to the facility from a rehabilitation facility. On 08/17/22 Interview with Director of Nursing A and Assistant Director of Nursing B revealed R172 records lacked the "FCS" being performed when the resident exhibited a significant change, and the "NSA" being updated when the resident experienced a change of condition and it further lacked the required interventions/healthcare services the resident would have required based on the "FCS" results showing the significant change. - Record review for R212, revealed an admission date of 09/30/2019 with diagnoses of hypertension, mood disorder, hearing loss, dementia, chronic obstructive pulmonary disease, unsteady gait, major depressive disorder, muscle weakness, colostomy present. Record review of the "FCS" dated 09/07/21 identified the resident required physical assistance with bathing and medication	S3092		

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S3092	Continued From page 24 management. He required supervision with dressing, and he was independent with toileting, transferring, walking and eating. He was continent of bladder, his cognition was intact, he could make himself understood and he usually understood others. He was marked with impaired hearing and used no mobility device. Record review of the combined "NSA/HSP" identified the following services provided and instructions to staff; Facility staff were to provide minimal assist with bathing, he was independent with dressing, continent of bowel and bladder, and independent with ostomy. He was independent with transfers, and eating, and required an escort to most meals and activities. He was marked with impaired judgement / memory and needed occasional monitoring/ guidance / redirection. Facility staff will offer reminders/ cues when necessary. Facility staff to manage resident mediations. Record review of the "Nursing Progress Notes" and primary care physician "Progress Notes" revealed the following entries; 04/03/22 a 02:00 PM - Resident continued on antibiotic treatment. He ambulated with a roller walker with stand by assist. Noted to have been dragging his right leg, he needed verbal cues to pick it up. Denies any pain. 04/03/22 at 11:00 pm - Resident alert and oriented times one. He was unable to voice concerns. He was lethargic, and he denied pain. Resident was not to answer questions. Emergency medical services called for altered mental status.	S3092		

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S3092	Continued From page 25 05/02/22 at 03:30 PM Resident arrived from rehabilitation facility. Uses a walker to ambulate. Resident now has a leg catheter and colostomy bag. Home health will be contacted for management. "Progress Note" dated 05/05/22 - Resident being seen for a follow up after his recent hospitalization. He was sent to hospital on 04/03/22. He was to have physical therapy, occupational therapy, speech therapy and skilled nursing. The functional status indicated he was dependent on a walker. 05/10/2022 at 09:30 PM - Resident had increased confusion and had been dragging his catheter bag, pulling on the tubing and there was blood in the catheter. "Progress Note" dated 05/10/22 - Nurse reported that resident had blood in his Foley catheter bag. During the visit the resident sat in the chair with the Foley catheter bag on the floor next to him. He appears very confused and nurse reported that he has been dragging his catheter bag when he walks around. "Progress Note" dated 05/19/22 - diagnoses of other abnormalities of gait and mobility. "Progress Note" dated 06/14/22 - indwelling Foley catheter present. Cognitive status; dementia. Gait instability; fall / safety precaution. 06/21/22 at 07:00 PM - resident trying to change is own colostomy bag.	S3092		

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S3092	Continued From page 26 08/03/22 at 09:00 PM - resident transferred to hospital for catheter inflammation/pain. 08/03/22 at 11:00 PM - resident returned to the facility by his grandson. Observation on 08/16/2022 during the noon time meal; resident sat at the end of the table with a staff member, a red walker was sitting next to his chair. After the resident ate his lunch he walked with the staff member out of the dining room. Interview on 08/17/22 with "Director of nursing" A and Assistant director of nursing B confirmed the resident record lacked an updated "FCS" and "NSA/HSP" identifying the resident required walker mobility device and had an indwelling urinary catheter. On 08/17/22 Interview with Director of Nursing A and Assistant Director of Nursing B revealed R212 records lacked the "FCS" being performed when the resident exhibited a significant change, and the "NSA" being updated when the resident experienced a change of condition and it further lacked the required interventions/healthcare services the resident would have required based on the "FCS" results showing the significant change. The administrator failed to ensure the licensed nurse reviewed and if necessary revised the negotiated service agreements for R172 and R212 to reflect the necessary healthcare services after a change of condition.	S3092		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication	S3201		

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S3201	Continued From page 27 (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3)(C) The facility reported a census of 102 residents with six residents sampled and two residents chosen for closed record reviews. Based on observation, interview, and record review the administrator failed to ensure licensed nurses (LN) or certified medication aides (CMA) remained with Resident (R)813 until her medication was ingested. Findings included: - Record review for R813 revealed an admission	S3201		

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S3201	Continued From page 28 date of 06/01/19 with the following diagnoses: syncope, major depressive disorder, unsteady gait, and history of fall. The 07/08/21 most recent "Functional Capacity Screen" (FCS) identified R813 required physical assistance with bathing, dressing, toileting, and management of medications and was marked for falls. The 07/08/21 most recent combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide minimal assistance daily for bathing, minimal assistance for dressing, moderate assistance for toileting, physical assistance for management of medications, and instruct R813 to wear non-skid footwear, keep her pathway lighted and free of obstacles, and keep assistive devices within reach to prevent falls. Observation on 08/17/22 at 03:38 PM revealed a medication administration cup containing six pills was on the desk in R813's apartment. On 08/17/22 at 03:38 PM R813 stated the pills were from that morning. All the CMA's set the pills down and then leave before she swallows them. On 08/17/22 at 04:20 PM CMA D stated he frequently sees leftover medications from the previous medication administration left in residents' rooms that were not swallowed. On 08/12/22 at 04:38 PM Administrative Staff A stated she expected LN's or CMA's to remain with residents until all their medications were	S3201		

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S3201	Continued From page 29 swallowed. The administrator failed to ensure LN's or certified medication aides CMA's remained with R813 until her medication was ingested.	S3201		
S3261 SS=F	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: K.A.R. 26-41-105 (f) (11) The facility reported a census of 102 residents. The sample included six "Residents" (R), and 2 closed record reviews. Based on observation, interview and record review, the administrator failed to ensure the facility nurses documented in the resident records all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions for R172, R212, R814, R810, and R813 Findings included: - Record review for R212 revealed an admission date of 09/30/2019 with diagnoses of hypertension, mood disorder, hearing loss, dementia, chronic obstructive pulmonary	S3261		

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S3261	Continued From page 30 disease, unsteady gait, major depressive disorder, muscle weakness, colostomy present. Record review on 08/16/22 of the "FCS" dated 09/07/21 identified the resident required physical assistance with bathing and medication management. He required supervision with dressing, and he was independent with toileting, transferring, walking and eating. He was continent of bladder, his cognition was intact, he could make himself understood and he usually understood others. He was marked with impaired hearing and used no mobility device. Record review of the combined "NSA/HSP" identified the following services provided and instructions to staff; Facility staff were to provide minimal assist with bathing, he was independent with dressing, continent of bowel and bladder, and independent with ostomy. He was independent with transfers, and eating, and required an escort to most meals and activities. He was marked with impaired judgement / memory and needed occasional monitoring/ guidance / redirection. Facility staff will offer reminders/ cues when necessary. Facility staff to manage resident mediations. Record review of the "Nursing Progress Notes" and primary care physician "Progress notes revealed the following entries; 04/03/22 a 02:00 PM - Resident continued antibiotic treatment. He ambulated with a roller walker with stand by assist. Noted to have been dragging his right leg, he needed verbal cues to pick it up. Denies any pain.	S3261		

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S3261	Continued From page 31 04/03/22 at 11:00 pm - Resident alert and oriented times one. He was unable to voice concerns. He was lethargic, and he denied pain. Resident was not to answer questions. Emergency medical services called for altered mental status. 05/02/22 at 03:30 PM Resident arrived from rehabilitation facility. Uses a walker to ambulate. Resident now has a leg catheter and colostomy bag. Home health will be contacted for management. "Progress Note" dated 05/05/22 - Resident being seen for a follow up after his recent hospitalization. He was sent to hospital on 04/03/22. He was to have physical therapy, occupational therapy, speech therapy and skilled nursing. The functional status indicated he was dependent on a walker. 05/10/2022 at 09:30 PM - resident had increased confusion and had been dragging his catheter bag, pulling on the tubing and there was blood in the catheter. "Progress Note" dated 05/10/22 - Nurse reported that resident had blood in his Foley catheter bag. During the visit the resident sat in the chair with the Foley catheter bag on the floor next to him. He appears very confused and nurse reported that he has been dragging his catheter bag when he walks around. "Progress Note" dated 05/19/22 - diagnoses of other abnormalities of gait and mobility. "Progress Note" dated 06/14/22 - indwelling	S3261		

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S3261	Continued From page 32 Foley catheter present. Cognitive status; dementia. Gait instability; fall / safety precaution. 06/21/22 at 07:00 PM - resident trying to change his own colostomy bag. 08/03/22 at 09:00 PM - resident transferred to hospital for catheter inflammation/pain. 08/03/22 at 11:00 PM - resident returned to the facility by his grandson. Observation on 08/16/2022 during the noon time meal; resident sat at the end of the table with a staff member, a red walker was sitting next to his chair with the indwelling catheter bag at his feet on the floor. After the resident ate his lunch he walked with the staff member out of the dining room. Interview on 08/17/22 with "Director of nursing" A and Assistant director of nursing B revealed the resident record lacked an updated "FCS" and "NSA/HSP" identifying the resident required walker mobility device and had an indwelling urinary catheter. The "Nursing Progress Notes" lacked the follow up charting for all incidents, symptoms, and other indications of illness of injury including the date, time of occurrence, action taken, and results of the actions. The record lacked alert charting for seventy-two hours after returning to the facility from a rehabilitation facility. On 08/17/22 Interview with Director of Nursing A and Assistant Director of Nursing B revealed R212 records lacked the documentation of all	S3261		

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S3261	Continued From page 33 incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions. - Record review for R172 revealed an admission date of 01/09/20 with diagnoses of hypertension, mood disorder, dementia, chronic obstructive pulmonary disease, chronic kidney disease, unsteady gait, muscle weakness and presence of colostomy. Record review of the "FCS" (Functional Capacity Screen) dated 10/01/21 identified R712 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. He required supervision with his medications, he was occasionally incontinent, and his cognition was intact. He was understandable and had the ability to understand others. He was marked as a fall risk and used a walker assistive device. Record review of the combined "NSA/HSP" (Negotiated Service Agreement/Healthcare Service Plan) dated 10/01/21 identified / instructed staff to provide the following healthcare services; he was independent with all activities of daily living, ambulation, and care of the ostomy. His judgement and memory were good. Record review of the facility document titled "Negotiated Service Agreement Addendum" included the following Fall / Safety; Resident will keep pendent within reach at all times. If observed without, facility staff will offer reminders and home health for	S3261		

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S3261	Continued From page 34 physical therapy. Signed by R712 on 11/03/21. Record review of R172 "Nursing Progress Notes" and Primary Care Physician notes revealed the following entries; 11/02/21 at 08:45 AM - Resident found on floor in apartment by kitchen staff when delivering room tray. Nursing staff notified. Maintenance manager assisted in locating pendant resident placed pendant in a box. Pendant placed around residents' neck. Resident has no complaints of pain or discomfort noted at this time. Called family and no numbers were available Resident stated that he slid off the side of his bed. "Resident educated on importance of wearing pendant at all times". "Progress Note"/ Primary Care Physician notes date 01/27/22 - Identified resident to have a diagnosis of major depressive disorder in partial remission. In house psychiatry following. "Progress Note"/ Primary Care Physician notes dated 06/14/22 - Resident was ambulating with a walker. During this visit he reported that he was becoming more forgetful and had difficulty with finding words when he was trying to say something. 06/22/22 at 12:00 PM - "Notified by other staff that resident found on the floor near closet with his walker located in living room". Resident does not recall how he ended up there. Resident is alert and oriented times three but hitting head could not be ruled out. Resident willing to be evaluated by emergency room. Resident was transported to hospital by emergency medical	S3261		

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S3261	Continued From page 35 services. 06/24/22 05:00 PM- Resident back around 04:50 PM calm and pleasant. denied pain, no complaints. 06/28/22 at 11:00 AM - Resident alerted staff via his call light. Resident found on floor in bathroom. He was alert and oriented times three. He stated he lost his balance while changing ostomy bag. Denies hitting head. Complaint of pain in left leg/hip with limited range of motion or ability to sit or stand. Resident requested emergency medical services transport to hospital. "Physician Order" dated 07/12/22 - discharge home on 07/14/22 with current medications, home health, physical therapy and occupational therapy to evaluate and treat. 07/14/22 at 01:00 PM - Resident returned from rehabilitation. Will have next shift on complete return assessment. "Progress Note"/ Primary Care Physician dated 07/19/22 - stated resident uses a walker for mobility fall and safety precaution; monitor. 07/29/ (no year recorded) at 02:30 AM - Resident attempted to get out of bed to take off extra layers of clothing. Resident stated when he stood up he felt weak and slid himself to the floor with the side of his bed. No injuries noted. 07/31/22 (no time recorded) - Resident found sitting in recliner. Resident has decreased alertness, increased weakness and unable to	S3261		

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S3261	Continued From page 36 stand. Resident transported to hospital for evaluation. Record review of the progress notes provided by the hospital signed on 07/31/22 revealed the resident was hospitalized the end of June and in early July 2022 for recurrent falls, weakness and weight loss. As of 08/18/2022 resident remained in the hospital. The "Nursing Progress Notes" lacked the follow up charting for all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the actions. The record lacked alert charting for seventy-two hours after returning to the facility from a rehabilitation facility. On 08/17/22 Interview with Director of Nursing A and Assistant Director of Nursing B revealed R172 remained in the hospital. They confirmed R172 records lacked the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions. - Record review for R814 revealed an admission date of 07/08/19 with the following diagnoses: acute and chronic respiratory failure with hypoxia, congestive heart failure, type two diabetes mellitus, and malnutrition. The 02/10/22 Annual "Functional Capacity Screen" (FCS) identified R814 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, eating, and management of medications and treatments. She was occasionally incontinent of bladder and was	S3261		

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S3261	Continued From page 37 marked for falls and impaired vision. The 02/10/22 combined Annual "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide minimal assistance twice weekly for bathing, minimal assistance for dressing and toileting, stand-by assistance as R814 directed for transfers, she propelled herself in her wheelchair but may need assistance for long distances; assistance with opening packages as R14 directed for eating, physical assistance with management of medications, oxygen per nasal cannula for treatments, and assistance with toileting. Staff were to instruct R814 to remain seated and call for assistance if she felt weak or dizzy to prevent falls. The 02/14/22 12:00 "Nursing Progress Note" documented R814 returned to the facility with normal vital signs and was able to transfer self. R814's record lacked documentation of any incidents, symptoms, illness or injury that led to prior transport from the facility before she returned on 02/14/22. The 06/29/22 03:30 PM "Nursing Progress Note" documented R814 was sent to the hospital for "overall weakness, low vitals, and unable to toilet herself." R814's record lacked documentation of action taken, results of the action and if her physician or family were notified on 06/29/22. The 07/23/22 01:00 PM "Nursing Progress Note" documented R814 returned to the facility. This	S3261		

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S3261	Continued From page 38 was the last nurse's note documented for R814. The next page of the "Nursing Progress Notes" was blank except an attached sticky note read "114 fell @ 2:15 AM called 911 for assist!" R814's record lacked documentation of any incident, symptoms, illness or injury, including the date, time, action taken, results of the action, or if her physician or family were notified on 07/23/22. On 08/17/22 at approximately 12:54 PM Administrative Staff A stated she could not recall what happened on 02/14/22 to cause R814 to be transported out of the facility. She confirmed it was not documented in R814's record. - Record review for R810 revealed an admission date of 07/08/19 with the following diagnoses: anxiety, depression, dementia, and congestive heart failure. The 12/23/21 annual FCS identified R810 required supervision with bathing and dressing, physical assistance with management of medications, and was frequently incontinent of bladder. The 12/23/21 NSA/HCP directed facility staff to provide cueing for bathing, she was independent with dressing, physical assistance for management of medications, and nursing staff to adjust her bladder stimulator as she directed and to notify her physician of increased urinary discomfort. The 11/04/21 05:00 PM "Nurse Progress Note" documented bladder stimulator was increased	S3261		

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S3261	Continued From page 39 "to 1.2 per resident and family request." The 11/30/21 12:00 PM "Nurse Progress Note" documented bladder stimulator was increased "to 1.4 per resident request." The 01/12/22 02:20 PM "Nurse Progress Note" documented bladder stimulator was increased "to 1.8, family notified." A physician appointment was requested for complaints of urinary frequency. The 07/04/22 10:15 PM "Nurse Progress Note" documented R810 returned from the emergency room where she received and antibiotic injection for a urinary tract infection (UTI). The 07/04/22 10:30 PM late entry "Nurse Progress Note" documented R810 called EMS for transport to the hospital for no urination for one week. On 08/17/22 at 12:54 PM Administrative Staff A stated they were working on getting a catheter placed for R810 to help with her recurring UTI's. She confirmed R810's record lacked necessary documentation. On 08/17/22 at 03:23 PM R810 stated she had a bladder stimulator placed by a urologist. The nurses turned it up every two to three weeks and have turned it up as far as it will go. It is now so painful she cannot use it and Administrative Nurse B was "coming tomorrow to turn it off because I'm getting a catheter." She was hopeful the catheter would solve her problems. She had "a bad UTI on July 4th and took all the antibiotics". She stated she doesn't know if she	S3261		

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S3261	Continued From page 40 has an infection now, but it felt like it. R810's record lacked documentation between 01/12/22 and 07/04/22 (six months) including urinary symptoms, bladder stimulator adjustments, or physician notification of bladder discomfort until she went to the emergency room by EMS on 07/04/22. - Record review for R813 revealed an admission date of 06/01/19 with the following diagnoses: unsteady gait, syncope, major depressive disorder, unsteady gait, and history of fall. The 07/08/21 most recent "FCS" identified R813 required physical assistance with bathing, dressing, toileting, and management of medications and was marked for falls. The 07/08/21 most recent combined Annual "NSA/HSP" identified facility staff would provide minimal assistance daily for bathing, minimal assistance for dressing, moderate assistance for toileting, physical assistance for management of medications, and instruct R813 to wear non-skid footwear, keep her pathway lighted and free of obstacles, and keep assistive devices within reach to prevent falls. Review of "Nursing Progress Notes" from 08/03/21 until 08/15/22 revealed a note on 06/23/22 that R813 was doing well on antibiotic therapy for a UTI. The 06/21/22 "Progress Note" by Advanced Registered Nurse Practitioner (ARNP) C documented R813 examined R813 for abnormal urinalysis results and skin rash. She was	S3261		

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S3261	Continued From page 41 prescribed an antibiotic for the UTI and topical cream for a skin rash. R813's record lacked documentation of symptoms of illness including the date, time of occurrence, action taken and the results of the action regarding painful urination and skin rash. On 08/17/22 at 03:38 PM R813 stated she had several UTI's in a row. Her doctor did a test and put her on an antibiotic. She had used different topical creams for the skin rash. Her rash was still in her groin area but it was better than it was before. On 08/17/22 at 12:54 PM Administrative Staff A stated she was not aware R813 had a skin rash at this time, although she had a history of rash under her stomach fold. Administrative Staff A confirmed R813's record lacked documentation of urinary and skin symptoms.	S3261		