

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 C 02/22/2023
NAME OF PROVIDER OR SUPPLIER DELAWARE HIGHLANDS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 DELAWARE PARKWAY KANSAS CITY, KS 66109		
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S 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #178340, #178331, #178327, #178119, #176892, #176862, #176787, and #175274 at the above named assisted living conducted on 02/21/23 - 02/23/21.	S 000		
S 135 SS=E	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)(B)	S 135		

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

TITLE

(X6) DATE

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S 135	Continued From page 1 The facility reported a census of 116 residents with five residents included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure licensed staff notified the residents' physicians and legal representatives or designated family members when Resident (R) 221 acquired pressure wounds, R223 fell and suffered foot pain with bruising, and R224 tested positive for COVID. Findings included: - Record review for R221 revealed an admission date of 04/03/20 with the following diagnoses: Alzheimer's disease and muscle weakness. The 01/10/23 "Functional Capacity Screen" (FCS) identified R221 required physical assistance with bathing, dressing, and management of medications; supervision with toileting; was independent with transfers, walking/mobility, and eating; was sometimes incontinent of bladder; had short-term memory loss; and was understandable and understood others during communication. The 01/10/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff would provide minimal assistance with bathing and dressing; stand-by assistance with toileting and incontinence care; escort to all meals; management of medications; and reminders, cueing, and redirection during times of forgetfulness. R221's record lacked evidence of documentation	S 135		

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S 135	Continued From page 2 by licensed nursing staff that her physician and legal representative or designated family member was notified when she developed open pressure wounds on the back of her legs and buttocks. On 02/21/23 at 03:24 PM an unidentified family member of R221 stated the facility never informed her of the wounds. During a visit on 02/01/23 a Certified Nurse Aide (CNA) told her there were wounds on R221's back legs and buttocks. - Record review for R223 revealed an admission date of 07/08/19 with the following diagnoses: history of cerebrovascular accident, depression, and anxiety. The 01/09/23 "FCS" identified R223 required supervision for bathing, dressing, and toileting; physical assistance with management of medications; was frequently incontinent of bladder; had short-term memory loss, memory/recall, and decision-making cognitive impairments; and was marked for falls, impaired vision, impaired hearing, and impaired decision making. The 01/09/23 "NSA" identified facility staff would provide R223 supervision for bathing, cueing for dressing, and minimal assistance and cueing for toileting; they would provide management of medications; she wore briefs for bladder incontinence; staff instructed her to wear non-skid footwear, keep pathway free of obstacles and properly lighted, place assistive devices such as walker/cane within reach and observed her environment for potentially unsafe	S 135		

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S 135	Continued From page 3 conditions to prevent falls; and staff provided occasional monitoring, guidance, and redirection for impaired decision making. Impaired vision and impaired hearing were not addressed on R223's "NSA." The 12/08/22 "Patient Report" documented R223 was provided an x-ray of her right foot for "post fall pain in the left foot with bruising." R223's record lacked evidence of documentation by licensed nursing staff that her physician and legal representative or designated family member was notified when she fell and had complaints of foot pain with bruising. - Record review for R224 revealed an admission date of 08/21/22 with the following diagnoses: acute kidney failure and cognitive communication deficit. The 08/31/22 "FCS" identified R224 was marked for impaired decision making. The 08/31/22 "NSA" identified facility would provide occasional monitoring, guidance, and redirection for impaired decision making. The 12/28/22 COVID test "Result Summary" for R224 documented a positive result. There was a handwritten note at the bottom of the page signed by unidentified licensed nurse that Doctor M was notified. R224's record lacked evidence of documentation by licensed nursing staff that her physician and legal representative or designated family member was notified when she tested positive for	S 135		

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S 135	Continued From page 4 COVID. On 02/22/23 at approximately 03:40 PM Administrative Nurse C confirmed licensed nursing staff notified a physician (Doctor M) who was not R224's physician of the positive COVID test result. She confirmed R224's physician and designated family member were not notified. On 02/22/23 at approximately 03:28 PM Administrative Nurse B confirmed R221, R223, and R224's records lacked evidence of documentation that their physicians and legal representatives or designated family members were notified when R221 acquired pressure wounds, R223 fell and suffered foot pain with bruising, and R224 tested positive for COVID. The administrator failed to ensure licensed staff notified the residents' physicians and legal representatives or designated family members when Resident (R) 221 acquired pressure wounds, R223 fell and suffered foot pain with bruising, and R224 tested positive for COVID.	S 135		
S3015 SS=F	26-41-101 (c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the facility; (2) implementing operational policies and procedures for the facility; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator 's or	S3015		

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S3015	Continued From page 5 operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(c)(3) The facility reported a census of 116 residents. Based on interview and record review the administrator failed to authorize in writing a designee to act on the administrator's behalf in his absence. Findings included: Observation on 02/21/23 at 09:38 AM revealed Administrative Staff A was not present in the facility. On 02/21/23 at 09:41 AM housekeeping staff L stated Administrative Staff was not present in the facility because he was on vacation. His normal schedule was Tuesday and Thursday but sometimes he worked three days a week. On 02/21/23 at 12:00 PM Administrative Nurse B stated she was in charge of the facility when Administrative Staff A was absent but there was not a written statement authorizing her to act on his behalf in his absence. On 02/23/23 at 11:02 PM Administrative Staff A confirmed he had not authorized in writing a designee to act on his behalf during his absence. The administrator failed to authorize in writing a designee to act on the administrator's behalf in	S3015		

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S3015	Continued From page 6 his absence.	S3015		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 116 residents with five residents included in the sample and one closed record review. Based on observation, interview, and record review the administrator failed to protect one resident from neglect by the failure to implement a method of identifying high-risk for elopement residents, inform staff what to do when a resident was missing, and to secure all exit doors. Cognitively impaired Resident (R) 221 exited the facility through an unlocked and non-alarmed door to the outside without staff knowledge. She was found approximately 20 steps from the nearest exit door where she had lain in a landscape bed in 34-degree weather wearing a top, an adult incontinence brief, and slippers with nothing covering her legs for undetermined amount of time. She was found by housekeeping staff on their way to the trash dumpster. This place the	S3026		

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S3026	Continued From page 7 resident in Immediate Jeopardy. Findings included: - Record review for R221 revealed an admission date of 04/03/20 with the following diagnoses: Alzheimer's disease and muscle weakness. The 01/10/23 "Functional Capacity Screen" (FCS) identified R221 required physical assistance with bathing, dressing, and management of medications; supervision with toileting; was independent with transfers, walking/mobility, and eating; was sometimes incontinent of bladder; had short-term memory loss; and was understandable and understood others during communication. The 01/10/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff would provide minimal assistance with bathing and dressing; stand-by assistance with toileting and incontinence care; escort to all meals; management of medications; and reminders, cueing, and redirection during times of forgetfulness. The 02/18/23 at 08:10 AM "Nursing Progress Note" documented R221 was found outside by kitchen staff with the complaint of being cold. She was taken by ambulance to the hospital for evaluation. The 02/18/23 at 08:00 PM "Nursing Progress Note" documented R221 was admitted to the hospital for a diagnosis of hypothermia. R221's record lacked evidence of documentation	S3026		

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S3026	Continued From page 8 of wandering or an elopement risk assessment. The facility's incident report documented R221 was found in the back parking lot on 02/18/23 at 08:30 AM. She was unable to describe what happened or how long she had been there. She was wearing pajamas from the previous night. Staff placed blankets on her and called 911. The 02/18/23 "History and Physical" by the hospital physician documented R221 had "advanced dementia" and was brought to the emergency room (ER) for evaluation for cold exposure. Her body temperature was 90 degrees Fahrenheit (F). On 02/21/23 at 09:55 AM Administrative Nurse C stated all doors on the first floor were unlocked to exit and not alarmed. (Except the south hall exit door was set to activate by residents' pendants.) However, the exit doors were locked to re-entry. If a resident went out a side exit door, they would have to re-enter the building by walking around to the front main entrance. The main entrance door was locked to enter between 08:00 PM and 08:00 AM. Anyone wishing to enter during that time could call the phone provided in the entryway for staff to let them in. On 02/21/23 at 10:51 AM Administrative Nurse B stated R221 was in the hospital because she had an unwitnessed fall outside on 02/18/23. Administrative Nurse B was investigating the incident and did not know how long R221 had been outside. Observation on 02/21/23 at 02:40 PM revealed a possible route R221 took to exit the facility. It	S3026		

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S3026	Continued From page 9 was approximately 42 steps from her room door to the stairwell door at the end of the hallway. Then down one flight of stairs where there were two doors. One door to enter the main floor of the facility or the other to exit the building. On the inside of the exit door leading to the outside of the building was a sign that read. " This door is for exit only, locked from inside." From the exit door to the location Administrative Nurse A pointed out where R221 was found lying in a landscape bed against the back side of the building was approximately 20 steps. The weather on 02/18/23 according to Wunderground.com was 34 degrees Fahrenheit with a wind speed of 16 mile per hour (MPH) at 07:53 AM. On 02/21/23 at 03:16 PM Administrative Nurse B stated she was not sure if R221 was wearing her call pendant at the time she exited the facility. On 02/21/23 at 03:24 PM unidentified family member of R221 stated facility informed her R221 wandered inside the facility but had never gone outside. R221 refused to wear her call pendant or push the call button in the bathroom because she did not know what they were for. The family member stated she showed R221 how to push the pendant and bathroom call light buttons but R221 forgot to do it. The family member stated Administrative Nurse C informed her on 02/01/23 that facility staff would check on R221 every hour to make sure she was ok. On 02/21/23 at 04:20 PM Certified Nurse Aid (CNA) D stated R221 was confused and had difficulty following instructions. She would not	S3026		

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S3026	Continued From page 10 use her walker even when staff place it right beside her. On 02/22/23 at 10:22 AM Licensed Nurse E stated she worked the day shift on 02/18/23. When she arrived for her shift, a night nurse had not been on duty the night before and the night shift aids had already left. It was an hour into her shift on 02/18/22 when the CNAs told her they could not find R221. She initiated a room-to-room search. During the search someone radioed over the walkie-talkie system R221 had been found outside. Licensed Nurse E went outside to provide blankets and called 911. She gathered paperwork together for EMS while they loaded R221 into the ambulance. She did not have time to perform an assessment or obtain vital signs for R221 before she left for the hospital. Licensed Nurse E stated R221 could not remember the location of her apartment or dining room. She was not aware if R221 was provided regular safety checks. On 02/22/23 at 10:33 AM Certified Medication Aid (CMA) F stated he was familiar with R221 as he sometimes passed medications on the second floor where her apartment was located. He stated she was "demented big time." She was often awake during the night. She was confused to the point that she didn't realize when she had just eaten. Staff would provide food for her and "two minutes later she would say she was hungry." Staff had to remind her of her apartment number so she could find her room. Staff were to check on R221 regularly because she was incontinent and got up night confused and wandering. CMA F stated he witnessed on one occasion R221 gathered her things and said, "Mom and Dad are	S3026			

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S3026	Continued From page 11 coming to get me." She would walk to the doors at the ends of the hallways, open the doors, see the stairs, and turn around come back. She would enter the elevator if the door was open but did not know how to push the button to choose where to go. When the door opened again, she would step out. On 02/22/23 at 10:47 AM Licensed Nurse G stated R221 was cognitively impaired and exhibited wandering behavior which required staff redirection. She did not exhibit exit-seeking behavior but if she wandered out a door, she "would just keep going." When first floor staff sent her up the elevator, they would radio ahead to notify second floor she was coming so they could direct her to her room. Licensed Nurse G stated staff checked on R221 every two hours during the day, but she did not know if R221 was checked during the night. On 02/22/23 at 11:12 AM CNA H stated R221 required checks two-hour bathroom checks, escort to meals, and staff assistance to the bathroom before and after meals. When R221 wandered, CNA H stated she would redirect her to her room. On 02/22/23 at 11:21 AM CNA I stated R221 was confused and wandered inside the facility because she was hungry or wanted someone to talk to. CNA I stated she took R221 to the bathroom every two hours. On 02/22/23 at 02:49 PM housekeeping staff J stated she arrived to work on 02/18/23 at approximately 07:00 AM. She took trash to the outside dumpster behind the facility at	S3026		

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S3026	Continued From page 12 approximately 08:15 AM and saw R221 lying on her back in the landscape bed by the corner of the building. R221 wore a nightgown, an incontinence brief, and slippers with nothing covering her legs. Her glasses lay 12 inches behind her head and her walker was not present. R221 lay quietly with eyes closed. When housekeeping staff J said her name, R221 opened her eyes. Housekeeping staff J called a male resident who was outside to come over and watch over R221 while she went and told the first floor CMA she had found R221 outside. Housekeeping staff J stated she was not aware a resident was missing before taking out the trash. On 02/22/23 at 04:11 PM CMA K stated she worked night shift on the first floor the night of 02/17/23 to the morning of 02/18/23. She did not see R221 during the night although she had seen her wandering the first floor on other nights. She never knew if R221 took the elevator or the stairs because when CMA K worked at the nurse's stations R221 would "just show up and stand there." CMA K stated she would take R221 back upstairs for second floor staff to take her back to her room. On 02/23/23 information regarding staff elopement training, elopement drills, and/or missing resident being addressed during quarterly emergency management drills was requested. Facility failed to provide the requested information. The facility's 06/19/13 "Elopement and Missing Resident Policy" documented: "Time is of the essence when it is suspected that a resident is missing. . . the Missing Resident Alert will be	S3026		

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S3026	Continued From page 13 issued immediately." The administrator failed to protect one resident from neglect by the failure to implement a method of identifying her as a high-risk for elopement, failed to inform staff what to do when a resident was missing, and failed to secure all exit doors. This failure resulted in immediate jeopardy when cognitively impaired R221 exited the facility through an unlocked and non-alarmed door to the outside without staff knowledge. She was found approximately 20 steps from the nearest exit door where she had lain in a landscape bed in 34-degree weather wearing a top, an adult incontinence brief, and slippers with nothing covering her legs for an undetermined amount of time. She was found by housekeeping staff on their way to the trash dumpster. Jeopardy was removed on 02/21/23 when the following actions were documented by the facility in the "Corrective Action Plan" and accepted by the department at 07:07 PM. 1) Director Environmental Services (EVS) would install alarms on all exit doors. 2) Director of Nursing/Assistant Director of Nursing (DON/ADON) would train the current evening shift, oncoming night shift, and all shifts moving forward until all staff were trained to check the new door alarms to ensure proper functioning, monitoring at risk residents, and elopement protocol. 3) Facility-wide staff in-service to be completed by the end of February 2023. 4) If a resident exhibited increased confusion, agitation, or exit-seeking behavior, staff would notify the nurse to assess if 30-minute checks	S3026		

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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 C 02/22/2023
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
S3026	Continued From page 14 were required.	S3026		
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:	S3028		

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S3028	Continued From page 15 KAR 26-41-101(f)(3) The facility reported a census of 116 residents with five residents included in the sample and one closed record review. Based on interview and record review the administrator failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours. Findings included: - Record review for R221 revealed an admission date of 04/03/20 with the following diagnoses: Alzheimer's disease and muscle weakness. The 01/10/23 "Functional Capacity Screen" (FCS) identified R221 required physical assistance with bathing, dressing, and management of medications; supervision with toileting; was independent with transfers, walking/mobility, and eating; was sometimes incontinent of bladder; had short-term memory loss; and was understandable and understood others during communication. The 01/10/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff would provide minimal assistance with bathing and dressing; stand-by assistance with toileting and incontinence care; escort to all meals; management of medications; and reminders, cueing, and redirection during times of forgetfulness. The 02/18/23 at 08:10 AM "Nursing Progress Note" documented R221 was found outside by kitchen staff with the complaint of being cold. She was taken by ambulance to the hospital for	S3028		

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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 C 02/22/2023
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S3028	Continued From page 16 evaluation. The 02/18/23 at 08:00 PM "Nursing Progress Note" documented R221 was admitted to the hospital for a diagnosis of hypothermia. The 02/21/23 Resident Roster provided by the facility indicated Resident (R) 221 was in the hospital. On 02/21/23 at 10:51 AM Administrative Nurse B stated Resident (R) 221 had fallen outside of the facility on 02/18/2. R221 was taken to the hospital because it was unknown how long she had been outside. Administrative Nurse B confirmed she did not report to the department within 24 hours of the incident. The administrator failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours.	S3028		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident 's functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 116 residents with five residents included in the sample and one closed record review. Based on interview	S3082		

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S3082	Continued From page 17 and record review the administrator failed to ensure designated facility staff ensured the "Functional Capacity Screen" (FCS) for Resident (R) 221 accurately reflected her functional capacity status at the time of screening. Findings included: - Record review for R221 revealed an admission date of 04/03/20 with the following diagnoses: Alzheimer's disease and muscle weakness. The 01/10/23 "Functional Capacity Screen" (FCS) identified R221 had short-term memory loss. The 01/10/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff would provide reminders, cueing, and redirection during times of forgetfulness. R221's "FCS" lacked evidence of documentation of long-term memory loss, memory/recall, and decision-making cognitive impairments; and lacked documentation of impaired decision making and wandering behavior. The 02/18/23 at 08:10 AM "Nursing Progress Note" documented R221 was found outside by kitchen staff with the complaint of being cold. She was taken by ambulance to the hospital for evaluation. The 02/18/23 "History and Physical" by the hospital physician documented R221 had "advanced dementia."	S3082		

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S3082	Continued From page 18 On 02/21/23 at 03:24 PM unidentified family member of R221 stated facility informed her R221 wandered inside the facility but had never gone outside. R221 refused to wear her call pendant or push the call button in the bathroom because she did not know what they were for. The family member stated she showed R221 how to push the pendant and bathroom call light buttons but R221 forgot to do it. On 02/21/23 at 04:20 PM Certified Nurse Aid (CNA) D stated R221 was confused and had difficulty following instructions. She would not use her walker even when staff place it right beside her. On 02/22/23 at 10:22 AM Licensed Nurse E stated R221 could not remember the location of her apartment or dining room. On 02/22/23 at 10:33 AM Certified Medication Aid (CMA) F stated was "demented big time." She was often awake during the night. She was confused to the point that she didn't realize when she had just eaten. Staff would provide food for her and "two minutes later she would say she was hungry." Staff had to remind her of her apartment number so she could find her room. Staff were to check on R221 regularly because she was incontinent and got up night confused and wandering. CMA F stated he witnessed on one occasion R221 gathered her things and said, "Mom and Dad are coming to get me." She would walk to the doors at the ends of the hallways, open the doors, see the stairs, and turn around come back. She would enter the elevator if the door was open but did not know how to push the button to choose where to go. And when the door	S3082		

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S3082	Continued From page 19 opened again, she would step out. On 02/22/23 at 10:47 AM Licensed Nurse G stated R221 was cognitively impaired and exhibited wandering behavior which required staff redirection. When first floor staff sent her up the elevator, they would radio ahead to notify second floor she was coming so they could direct her to her room. Licensed Nurse G stated staff checked on R221 every two hours during the day, but she did not know if R221 was checked during the night. On 02/22/23 at 11:12 AM CNA H stated R221 required checks two-hour bathroom checks, escort to meals, and staff assistance to the bathroom before and after meals. When R221 wandered, CNA H stated she would redirect her to her room. On 02/22/23 at 11:21 AM CNA I stated R221 was confused and wandered inside the facility because she was hungry or wanted someone to talk to. On 02/22/23 at 04:11 PM CMA K stated she worked night shift on the first floor. If R221 wandered down to the first floor CMA K took R221 back upstairs for second floor staff to take her back to her room. On 02/22/23 at 10:19 AM Administrative Nurse C confirmed she was responsible for completing residents' "FCS's." On 02/23/23 at approximately 11:26 AM Administrative Nurse C confirmed R221's "FCS" was not accurate for her cognitive and wandering	S3082		

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S3082	Continued From page 20 status. The administrator failed to ensure designated facility staff ensured the "FCS" for R221 accurately reflected her functional capacity status at the time of screening.	S3082		
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 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)(1) The facility reported a census of 116 residents with five residents included in the sample and one closed record review. Based on interview and record review the administrator failed to	S3085		

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S3085	Continued From page 21 ensure the development of a "Negotiated Service Agreement" (NSA) for Resident (R) 221 based on her "Functional Capacity Screen" (FCS) regarding the services she received for management of treatments for wound care and for R223 regarding the services she received for impaired vision and impaired hearing. Findings included: - Record review for R221 revealed an admission date of 04/03/20 with the following diagnoses: Alzheimer's disease and muscle weakness. The 01/10/23 "FCS" identified R221 was independent with management of treatments. The 01/10/23 combined "NSA/Healthcare Service Plan" (HCP) failed to identify the services R221 would receive for the management of treatments. On 02/23/23 at 09:56 AM Administrative Nurse B stated wound care services were provided by home health. She confirmed wound care services were not addressed on R221's NSA. - Record Review for R223 revealed an admission date of 07/08/19 with the following diagnoses: history of cerebrovascular accident, depression, and anxiety. The 01/09/23 "FCS" identified R223 was marked for impaired vision and impaired hearing. The 01/09/23 combined "NSA/HCP" failed to identify the services R223 would receive for impaired vision and impaired hearing.	S3085		

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S3085	Continued From page 22 On 02/22/23 at 03:40 PM Administrative Nurse C confirmed impaired vision and impaired hearing were not addressed on R223's NSA. The administrator failed to ensure the development of an "NSA" for R221 based on her "FCS" regarding the services she received for management of treatments for wound care and for R223 regarding the services she received for impaired vision and impaired hearing.	S3085		
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 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 116 residents with five included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure a licensed nurse provided the necessary health care services that met the needs for Resident (R) 221 by the failure to document skin or wound	S3155		

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S3155	Continued From page 23 assessments including the time of origin, a description of the wounds, measurements, or a plan for the treatment of her wounds on the back of her legs and buttocks in her medical record. . Findings included: - Record review for R221 revealed an admission date of 04/03/20 with the following diagnoses: Alzheimer's disease and muscle weakness. The 01/10/23 "Functional Capacity Screen" (FCS) identified R221 required physical assistance with bathing, dressing, and management of medications; supervision with toileting; was independent with transfers, walking/mobility, and eating; was sometimes incontinent of bladder; had short-term memory loss; and was understandable and understood others during communication. The 01/10/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff would provide minimal assistance with bathing and dressing; stand-by assistance with toileting and incontinence care; escort to all meals; management of medications; and reminders, cueing, and redirection during times of forgetfulness. R221's record lacked evidence of documentation of skin assessments or wound assessments including time of origin, description of the wounds, measurements, or plan for the treatment of wounds. The 01/31/23 "Progress Note" by unidentified	S3155		

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S3155	Continued From page 24 outside provider nurse practitioner documented R221's coccyx area was red and irritated. She ordered prescription skin cream for treatment. The 02/08/23 "Wound Care" note by unidentified outside provider physician documented R221 had new wounds to the backs of both her legs with new orders to apply Triad cream to the wounds three times a week. The 02/20/23 hospital records for wound care consult at 12:28 PM documented a linear stage-two pressure ulcer on the back of R221's left thigh. On 02/21/23 at approximately 10:51 AM Administrative Nurse B stated a wound doctor came once a week to check on resident's who have wounds. On 02/21/23 at 03:24 PM an unidentified family member of R221 stated the facility never informed her of the wounds. During a visit on 02/01/23 a Certified Nurse Aide (CNA) told her there were wounds on R221's back legs and buttocks. On 02/21/23 at 04:20 PM CNA D stated R221 had wounds on the backs of her legs but was not sure how long the wounds had been there. Staff applied cream to the wounds every other time R221 went to the bathroom. On 02/22/23 at approximately 10:33 AM Certified Medication Aide (CMA) F stated R221 had sores that developed "about a month and a half ago." On 02/22/23 at 11:12 AM CNA H stated R221	S3155		

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S3155	Continued From page 25 had sores on her legs and bottom but she did not know when they started. Staff put cream on her sores. On 02/22/23 at 11:21 AM CNA I stated R221 had sores that she first noticed on 02/08/23 and informed Licensed Nurse G. On 02/09/23 a nurse practitioner examined the sores. On 02/22/23 at 02:08 PM Administrative Nurse C confirmed R221 had wounds on the back of her legs and buttocks. She stated the sores developed because R221 took herself to the toilet and forgot to get up from the toilet when she was done. On 02/22/23 at 03:28 PM Administrative Nurse B confirmed R221's record lacked evidence of documentation by the facility's licensed nursing staff regarding the wounds on the back of her legs and buttocks. The administrator failed to ensure a licensed nurse provided the necessary health care services that met the needs for Resident (R) 221 by the failure to document skin or wound assessments including the time of origin, a description of the wounds, measurements, or a plan for the treatment of her wounds on the back of her legs and buttocks in her medical record.	S3155			
S3261 SS=E	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	S3261			

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S3261	Continued From page 26 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 116 residents with five residents included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure staff provided documentation of all incidents including date, time of occurrence, action taken and results of the action when Resident (R) 221 acquired pressure wounds, R223 fell and suffered foot pain with bruising, and R224 tested positive for COVID. Findings included: - Record review for R221 revealed an admission date of 04/03/20 with the following diagnoses: Alzheimer's disease and muscle weakness. The 01/10/23 "Functional Capacity Screen" (FCS) identified R221 required physical assistance with bathing, dressing, and management of medications; supervision with toileting; was independent with transfers, walking/mobility, and eating; was sometimes incontinent of bladder; had short-term memory loss; and was understandable and understood others during communication. The 01/10/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff would provide minimal	S3261		

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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
S3261	Continued From page 27 assistance with bathing and dressing; stand-by assistance with toileting and incontinence care; escort to all meals; management of medications; and reminders, cueing, and redirection during times of forgetfulness. The 01/31/23 "Progress Note" by unidentified outside provider nurse practitioner documented R221's coccyx area was red and irritated. She ordered prescription skin cream for treatment. The 02/08/23 "Wound Care" note by unidentified outside provider physician documented R221 had new wounds to the backs of both her legs with new orders to apply Triad cream to the wounds three times a week. The 02/20/23 hospital records for wound care consult at 12:28 PM documented a linear stage-two pressure ulcer on the back of R221's left thigh. R221's record lacked evidence of documentation by licensed nursing staff coccyx area was red and irritated including the time of occurrence, action taken, and results of the actions. R221's record lacked evidence of documentation by licensed nursing staff that she developed open pressure wounds on the back of her legs and buttocks including the time of occurrence, action taken, and results of the actions. On 02/21/23 at 04:20 PM CNA D stated R221 had wounds on the backs of her legs but was not sure how long the wounds had been there. Staff applied cream to the wounds every other time R221 went to the bathroom.	S3261		

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 C 02/22/2023
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
S3261	Continued From page 28 On 02/22/23 at approximately 10:33 AM Certified Medication Aide (CMA) F stated R221 had sores that developed "about a month and a half ago." On 02/22/23 at 11:12 AM CNA H stated R221 had sores on her legs and bottom but she did not know when they started. Staff put cream on her sores. On 02/22/23 at 11:21 AM CNA I stated R221 had sores that she first noticed on 02/08/23 and informed Licensed Nurse G. On 02/22/23 at 03:28 PM Administrative Nurse B confirmed R221's record lacked evidence of documentation by the facility's licensed nursing staff regarding the wounds on the back of her legs and buttocks. - Record review for R223 revealed an admission date of 07/08/19 with the following diagnoses: history of cerebrovascular accident, depression, and anxiety. The 01/09/23 "FCS" identified R223 required supervision for bathing, dressing, and toileting; physical assistance with management of medications; was frequently incontinent of bladder; had short-term memory loss, memory/recall, and decision-making cognitive impairments; and was marked for falls, impaired vision, impaired hearing, and impaired decision making. The 01/09/23 "NSA" identified facility staff would provide R223 supervision for bathing, cueing for dressing, and minimal assistance and cueing for	S3261		

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 C 02/22/2023
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
S3261	Continued From page 29 toileting; they would provide management of medications; she wore briefs for bladder incontinence; staff instructed her to wear non-skid footwear, keep pathway free of obstacles and properly lighted, place assistive devices such as walker/cane within reach and observed her environment for potentially unsafe conditions to prevent falls; and staff provided occasional monitoring, guidance, and redirection for impaired decision making. Impaired vision and impaired hearing were not addressed on R223's "NSA." The 12/08/22 "Patient Report" documented R223 was provided an x-ray of her right foot for "post fall pain in the left foot with bruising." R223's record lacked evidence of documentation by licensed nursing staff about a fall, complaints of foot pain, or bruising including the time of occurrence, action taken, and results of the actions. - Record review for R224 revealed an admission date of 08/21/22 with the following diagnoses: acute kidney failure and cognitive communication deficit. The 08/31/22 "FCS" identified R224 was marked for impaired decision making. The 08/31/22 "NSA" identified facility would provide occasional monitoring, guidance, and redirection for impaired decision making. The 12/28/22 COVID test "Result Summary" for R224 documented a positive result.	S3261		

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 C 02/22/2023
NAME OF PROVIDER OR SUPPLIER DELAWARE HIGHLANDS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 DELAWARE PARKWAY KANSAS CITY, KS 66109		
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S3261	Continued From page 30 R224's record lacked evidence of documentation by licensed nursing staff about testing positive for COVID including symptoms, time of occurrence, action taken, and results of the action. On 02/22/23 at approximately 03:40 PM Administrative Nurse B confirmed R221, R223, and R224's records lacked evidence of 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. The administrator failed to ensure staff provided documentation of all symptoms including date, time of occurrence, action taken and results of the action when R221 acquired pressure wounds, R223 fell and suffered foot pain with bruising, and R224 tested positive for COVID.	S3261		