

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2023
NAME OF PROVIDER OR SUPPLIER ANTHOLOGY OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with attached complaints #178553, #178447, #178226, #178220, #178202, #177926, #176169, #176178, #175030, #174724, #174418, #174428, #173833, #172443, #172231, and #171998 at the above named assisted living conducted on 03/06/23 - 03/08/23.	S 000		
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)(2) The facility reported a census of 89 residents	S3085		

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

TITLE

(X6) DATE

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S3085	Continued From page 1 with 11 included in the sample and one closed record review. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 12 identified the services he received to prevent falls, the services he received for a pressure wound, and the provider of the services for a pressure wound. Findings included: - Record review for R12 revealed an admission date of 09/02/21 with a diagnosis of cancer metastasized to the brain. The 01/17/23 "Functional Capacity Screen" (FCS) identified R12 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; was unable to perform management of medications and treatments; was incontinent of bladder; and had short-term and long-term memory loss, memory/recall, and decision-making cognitive impairments. The 05/12/22 (most recent) combined "NSA/Healthcare Service Plan" (HCP) identified facility staff would provide extensive assistance with bathing and dressing; total assistance with toileting; assistance with two staff for transfers; escort in a wheelchair to meals; facility staff would administer medications; he wore briefs for incontinence; and facility staff would provide direction, reminders, and cares in pairs for cognitive impairments. The "NSA" failed to identify the services R12 would receive to prevent falls and treat a	S3085		

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S3085	Continued From page 2 pressure wound and the provider of the services to treat the pressure wound. The 12/01/21 at 03:06 PM nursing "Progress Note" documented R12 had a new wound on his left outer ankle. The 04/12/22 at 01:38 PM nursing "Progress Note" documented R12 fell outside by the driveway. The 04/23/22 at 12:07 PM nursing "Progress Note" documented R12 was found by a CNA who went to check on him lying on his left side on the floor by his wheelchair. The 05/19/22 at 09:34 AM nursing "Progress Note" documented R12 was observed on his left side on the floor beside his bed with a skin tear on his left hand and arm, left side of his face was swollen, left eye was swollen shut, and he complained of abdominal pain. Emergency Medical Services (EMS) were called and R12 was transported to the hospital. On 03/06/23 at 03:35 PM Administrative Nurse B stated the "NSA" and "HCP" were combined in one document. On 03/08/23 at 09:36 AM Administrative Nurse C confirmed R12's "NSA" failed to identify the services he would receive to prevent falls and treat a pressure wound and the provider of the services to treat the pressure wound. The administrator failed to ensure the "NSA" for R12 identified the services he received to prevent falls, the services he received for a pressure wound, and the provider of the services	S3085		

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S3085	Continued From page 3 for a pressure wound.	S3085		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 89 residents with 11 included in the sample and one closed record review. Based on observation, interview, and record review Administrator A failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for Residents (R) 11 and R5. Findings included: - Record review for R5 revealed an admission date of 10/19/21 with the following diagnoses: spinal stenosis and carpal tunnel syndrome. The 09/06/22 "Functional Capacity Screen" (FCS) identified R5 required physical assistance with bathing, toileting, transfers, and walking/mobility. The 12/28/22 combined "Negotiated Service	S3171		

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S3171	Continued From page 4 Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided R5 moderate assistance with bathing, moderate assistance onto and off the toilet for toileting, occasional hands-on assistance with transfers, and occasional escort to meals and activities for walking/mobility. Record review lacked an annual assessment of the resident to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an annual assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. Observation on 03/07/23 at 02:33 PM revealed a bed assist device was attached to the left side of R5's bed. - Record review for R11 revealed an admission date of 11/30/22 with the following diagnoses: Dementia. The 01/17/23 "Functional Capacity Screen" (FCS) identified R11 required physical assistance with bathing, dressing, toileting, transfers, and walking/mobility. The 01/05/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCP) identified facility staff provided R11 assistance with bathing, dressing, toileting, standby assistance with transfers and occasional assistance with walk/mobility.	S3171		

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S3171	Continued From page 5 Record review lacked an assessment of the resident to confirm the device was not a restraint, an annual assessment of the resident to determine the purpose of the bedrail/assistive device and the resident's ability to safely use the device, an annual assessment of the bedrail/assistive device to ensure the device was securely attached to the bed or bedframe and posed no risk for entrapment. Observation on 03/07/23 at 02:24 PM revealed a bed assist device attached to the left side of R11's bed. The FDA (food and drug administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 listed 4 zones of greatest concern with specific measurements to reduce the risk of entrapment as follows: Zone 1 within the rail should measure less than 4 and 3/4 inches Zone 2 under the rail, between the rail supports or next to a single rail support should measure less than 4 and 3/4 inches Zone 3 between the rail and the mattress should measure less than 4 and 3/4 inches Zone 4 under the rail at the ends of the rail should measure less than 2 and 3/8 inches. On 03/07/23 at approximately 04:36 PM Administrative Nurse C confirmed there was no bed assist device assessment completed on R5 and R11. Administrator A failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist	S3171		

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S3171	Continued From page 6 safely without risk of entrapment, and to confirm the bed assist device was not a restraint for R 11 and R5.	S3171		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 89 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original package of four over the counter (OTC) medications in the memory care unit medication cart and six OTC medications in the second-floor medication cart. Findings included:	S3211		

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S3211	Continued From page 7 - Observation on 03/06/23 at 01:08 PM revealed Licensed Nurse D unlocked and opened the memory care unit medication cart which contained medications for the residents. The following OTC medications were not labeled with residents' full names: In the third drawer down: One bottle of vitamin D3 1000 international units (iu), 650 softgels, One bottle of iron 65 milligrams (mg), 100 tablets One bottle of melatonin 5 mg, 90 tablets One bottle of melatonin 5 mg, 120 tablets On 03/06/23 at approximately 01:08 PM Licensed Nurse D confirmed some OTC medications in the memory care unit medication cart were not labeled with residents' full names. Observation on n 03/06/23 at 01:30 PM revealed Certified Medication Aide (CMA) E unlocked and opened the second-floor medication cart which contained medications for the residents. The following OTC medications were not labeled with residents' full names: In the second drawer down: One bottle of Tylenol 325 mg, 100 tablets In the third drawer down: One bottle of vitamin D3 5000 iu, 400 softgels One bottle of Delsym 12-hour cough relief, 148 milliliters (ml) liquid One box of Mucinex 12-hour expectorant, 14 tablets In the fourth drawer down: One box of omeprazole 20 mg, 14 tablets	S3211		

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S3211	Continued From page 8 One bottle of One a Day multi-vitamins, 65 tablets On 03/06/23 at approximately 01:30 PM CMA E confirmed some OTC medications in the second-floor medication cart were not labeled with residents' full names. The facility's February 2022 "Over-the-Counter (OTC) Medications" policy documented "The resident's name should be written on their over-the-counter medication that is centrally stored." The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original package of four OTC medications in the memory care unit medication cart and six OTC medications in the second-floor medication cart.	S3211		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 89 residents with 11 included in the sample and one closed	S3261		

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S3261	Continued From page 9 record review. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents including the date, time of occurrence, action taken and results of the action when Resident (R)12 acquired a pressure wound. Findings included: - Record review for R12 revealed an admission date of 09/02/21 with a diagnosis of cancer metastasized to the brain. The 01/17/23 "Functional Capacity Screen" (FCS) identified R12 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; was unable to perform management of medications and treatments; was incontinent of bladder; and had short-term and long-term memory loss, memory/recall, and decision-making cognitive impairments. The 05/12/22 (most recent) combined "NSA/Healthcare Service Plan" (HCP) identified facility staff would provide extensive assistance with bathing and dressing; total assistance with toileting; assistance with two staff for transfers; escort in a wheelchair to meals; facility staff would administer medications; he wore briefs for incontinence; and facility staff would provide direction, reminders, and cares in pairs for cognitive impairments. The 12/01/21 at 03:06 PM nursing "Progress Note" documented the hospice nurse received new orders for dressing changes for a new wound on R12's left outer ankle.	S3261		

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S3261	Continued From page 10 R12's record lacked evidence of documentation by licensed staff regarding the development of a wound including the date, time of occurrence, action taken, and the results of the action. On 03/08/23 at approximately 09:36 AM Administrative Nurse C confirmed R12's records lacked evidence of documentation regarding a skin wound. The administrator failed to ensure licensed staff documented all incidents including the date, time of occurrence, action taken and results of the action when Resident (R)12 acquired a pressure wound.	S3261		
S3270 SS=D	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by:	S3270		

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S3270	Continued From page 11 KAR 26-41-104 (b) (5) (6) (8) The census equaled 89 residents. The sample included 11 residents. Based on record review and interview, Administrator A failed to ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including explosion, natural gas leak and missing resident. Findings included: - Review of the facility "Resident Emergency Protocols" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, lack of electrical and water service. The plan lacked documentation of review of explosion, natural gas leak and missing resident. Review of the "Resident Emergency Protocols" completed with residents on 04/05/22, 07/06/22 and 10/05/22. Interview on 03/08/23 at 09:29 AM with Administrator A confirmed "Resident Emergency Protocols" plan completed with residents lacked review of explosion, natural gas leak and missing resident. For all residents, Administrator A failed to ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including explosion, natural gas leak and missing resident.	S3270		

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S3299	Continued From page 12	S3299		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 89 residents. The facility had a main kitchen where food was stored and prepared. Based on observation and interview the administrator failed to ensure dietary staff stored an open bag of rice and an open bag of cornstarch in sealable containers and failed to ensure dietary staff removed dented cans to ensure foods were stored under safe conditions. Findings included: - Observation on 03/06/23 at approximately 12:39 AM in the main kitchen revealed a dry storage area that contained shelf-stable foods. One opened 50-pound bag of white rice sat upright on a shelf with an open gap at the top of the bag and one 50-pound bag of cornstarch sat upright on a shelf with a large tear down the side of the bag. The storage area contained a large rack that held gallon-sized cans of food items. One can of	S3299		

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S3299	Continued From page 13 cherry pie filling and one can of sliced pears had large dents in their sides. On 03/06/23 at approximately 12:39 AM Dietary Staff F confirmed the bags of rice and cornstarch were not stored under safe conditions and the dented cans were not to be stored with cans of food to be served to the residents. The administrator failed to ensure dietary staff stored an open bag of rice and an open bag of cornstarch in sealable containers and failed to ensure dietary staff removed dented cans to ensure foods were stored under safe conditions.	S3299		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c)	S3310		

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S3310	Continued From page 14 The facility reported a census of 89 residents. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for one of five sampled staff. Findings included: Administrative Nurse B's employee record revealed a hire date of 09/19/22. The first step of the two-step TB skin test was administered on 02/15/23 which was 156 days from date of hire. The department's June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented "Each new resident and new employee shall receive a two-step TST. . . within seven days of employment. . . " On 03/08/23 at approximately 10:32 AM Administrative Nurse B confirmed her record lacked evidence of documentation a TB skin test was completed within seven days of hire. The facility's October 2022 "Tuberculosis Testing - Team Members" policy documented "Each newly hired team member will be screened for TB infection and disease after an employment offer has been made but prior to the team member's duty assignment." The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/08/2023
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