

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF SHAWNEE OPERATIONS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16207 MIDLAND DRIVE SHAWNEE, KS 66217		
(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 deficiencies represent the findings of a Re-Licensure Survey with complaint investigations 161922, 163696, 167699, 168191, 168872, 170180, 171947, 172560, 172696, 173081, 173225, 174907, 174929, 175173, 175600 and 180991 for the above named Assisted Living facility conducted on 06/19/23, 06/20/23, 06/21/23, and 06/22/23.	S 000		
S3026 SS=E	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 43 residents (R). The sample included three residents and seven focused record reviews. Based on interview and record review for two (R3, R5) of three sampled residents and for two (R11, R12) of seven focused record reviews the executive director failed to ensure the four residents were not subjected to neglect when staff failed to monitor for the functionality of the door alarms daily as the elopement policy directs and when	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 staff failed respond to the door alarms when the residents went out the exit doors unattended. Findings included: - Review of R3's medical record revealed she moved into the facility on 06/11/21 with diagnosis of dementia. Review of R3's combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) dated 07/06/22 identified the resident needed supervision for transfers and walking/mobility. It identified she had impaired cognition but was not at risk for falls and did not wander. Review of R3's "Service Plan" effective on 09/21/22 did not include specific interventions related to elopement risk as the facility did not identify the resident at risk for elopement. R3's "Assisted Living Admission/Annual/Bi-Annual/Sig Change Assessment" dated 12/20/21 and 07/22/22 did not identify the resident was at risk for elopement. Review of the resident's record revealed that on 09/21/22 at 10:57 AM the facility received a phone call from the medical facility down the street that the resident was at the office confused and thinking she may have had an appointment. Review of the nursing progress notes prior to 09/21/22 did not identify the resident as exit seeking, wandering, or unaware of her own safety needs.	S3026		

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S3026	Continued From page 2 On 09/21/22 the nursing progress notes revealed R3 walked down to the medical center believing that she had an appointment. The staff there, alerted the facility and facility staff went and picked R3 up. Resident was assessed for any injuries, and none were identified. Vitals signs were normal, and she had on appropriate clothing for the weather. The nursing progress notes included follow up notes for the next week that the resident had not made attempts to leave the facility. Review of the facility investigation revealed she was sitting on the couch at 09:40 AM. At 9:53 AM the resident came out of her room and then tried to go back in her room, but the door appeared to be locked. She then walked down the north hall to the end and went out the door at 09:57 AM. The investigation identified the door was alarmed but was the kind that stopped alarming once the door closed. The resident had her walker with her and then the medical facility down the street contacted the facility to alert them that the resident was at their facility and did not have an appointment. Review of the "TELS" monitoring system for testing of the doors, locks, gates, and alarms revealed it was done weekly between February of 2022 and December of 2022. The facility then purchased new alarms that were like the current ones but continued to alarm even when the doors shut. On 01/17/23 a local company installed magnetic locks on all external doors and returned on 05/04/23 to program the keypad to work the locks and bring the system	S3026		

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S3026	Continued From page 3 online. There is no evidence to show that staff responded to the door alarm that sounded to see if someone had gone out the door. Review of the undated elopement policy revealed the facility will perform and document door alarm testing daily to determine alarms are functioning. The executive director failed to ensure that staff responded to exit door alarms to see if a resident had gone outside unsupervised and failed to ensure door alarms were checked daily for functionality as directed in the facility policy. - Review of R5's medical record revealed she moved into the facility on 01/09/23 with diagnoses of major depressive disorder and epilepsy. Review of R5's Combined "Functional Capacity Screen/Negotiated Service Agreement" dated 02/24/22 identified the resident was independent with all activities of daily living, had difficulty with long term memory and decision-making ability. R5's "Assisted Living Admission/Annual/Bi-Annual/Sig Change Assessment" dated 02/24/22 identified the resident wandered and had altered perception at times but did not identify her at risk for elopement. R5's "Service Plan" dated 06/09/20 included that she had a pet and would be independent with taking her pet outside as needed.	S3026		

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S3026	Continued From page 4 Review of R5's nursing progress notes between 10/01/22 and 06/21/22 included documentation of delusions thinking related to family and looking for them but did not include the resident wandering about unaware of her own safety needs or attempting to leave the facility. The progress notes also included the following documentation: 06/21/2022: Staff were walking through the courtyard and saw resident on the other side of the gated fence without her walker just standing in the grass. Resident was assisted back into the courtyard and her walker was located outside of the southeast door. Res stated that "a man" told her that there were rooms 900 and up out around the back door but she couldn't find the rooms. She stated that she was looking for her mother's room that she thought it was in the 900's. Review of the facility investigation staff interviews recorded staff had seen the resident walking in the halls with her dog in the morning after breakfast. Staff also reported she was last seen in the front lobby area at 10:00 AM. At approximately 11:30 AM staff observed the resident on the outside of the courtyard gate without her walker and did not know how she had gotten out of the facility. They found her walker just outside the southeast exit door and assumed she had gone out that door. Staff got her walker, unlocked the gate, and brought her back into the facility. The resident had been outside potentially for 1 to 1.5 hours. The investigation revealed staff placed a new door alarm on the southeast door and a new elopement risk assessment completed. The	S3026		

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S3026	Continued From page 5 facility also updated the alarm battery change schedule for the and conducted a staff in-service on elopement. Review of the "TELS" monitoring system for testing of the doors, locks, gates, and alarms revealed it was done weekly between February of 2022 and December of 2022. There is no evidence to show that staff responded to the southeast door alarm that sounded to see if someone had gone out the door. Review of the undated elopement policy revealed the facility will perform and document door alarm testing daily to determine all alarms are functioning. The executive director failed to ensure that staff responded to exit door alarms to see if a resident had gone outside unsupervised and failed to ensure door alarms were checked daily for functionality as directed in the elopement policy. - Review of R11's medical record revealed she moved into the facility on 07/01/22 with diagnoses of anxiety and macular degeneration. R11's combined "Functional Capacity Screen/Negotiated Service Agreement" dated 10/13/22 identified the resident needed supervision with walking and used a walker as an assistive device. It also identified she had impaired cognition but had no wandering behaviors. R11's "Assisted Living	S3026		

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S3026	Continued From page 6 Admission/Annual/Bi-Annual/Sig Change Assessment" dated 10/13/22 revealed the resident had no wandering or exit seeking and was not identified at risk for elopement. Review of the facility investigation revealed on 10/22/22 at 02:55 PM maintenance staff went into the facility and told staff R11 was outside in the parking lot with another resident's family. The investigation revealed that at approximately 02:30 PM R11 walked toward the door on the north hall and Certified Nurse Aide (CNA) K went to get the resident. Before staff could reach the resident, she had opened the door and walked outside. CNA K brought the resident back into the facility, redirected the resident back down the hall and CNA K went the opposite direction. R11 proceeded down the hall and then went out the next exit door and proceeded to walk toward the back parking lot. The resident was out of the building for approximately 20 minutes. The investigation failed to identify if the door alarm sounded and/or if any staff responded to the door alarm. Review of the "TELS" monitoring system for testing of the doors, locks, gates, and alarms revealed it was done weekly between February of 2022 and December of 2022. Review of the undated elopement policy revealed the facility will perform and document door alarm testing daily to determine alarm is functioning. The executive director failed to ensure that staff responded to exit door alarms to see if a resident	S3026		

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S3026	Continued From page 7 had gone outside unsupervised and failed to ensure door alarms were checked daily for functionality as directed in the elopement policy. This allowed the residents to leave the facility undetected by staff.	S3026		
S3028 SS=E	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.	S3028		

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S3028	Continued From page 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(C)(E)(F) The facility reported a census of 43 residents(R). The sample included three residents, and seven focused record reviews. Based on interview, and record review the administrator failed to report the elopement of one (R12) of seven focused record reviews to the department within 24 hours. The administrator also failed to initiate, complete, and maintain a written record of a thorough investigation when R5 and R12 were found outside of the facility without staff knowledge Findings included: - Review of R5's medical record revealed she moved into the facility on 01/09/23 with diagnoses of major depressive disorder and epilepsy. Review of R5's Combined "Functional Capacity Screen/Negotiated Service Agreement" dated 02/24/22 identified the resident was independent with all activities of daily living, had difficulty with long term memory and decision-making ability. R5's "Assisted Living Admission/Annual/Bi-Annual/Sig Change Assessment" dated 02/24/22 identified the resident wandered and had altered perception at times but did not identify her at risk for elopement.	S3028		

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S3028	Continued From page 9 R5's "Service Plan" dated 06/09/20 included that she had a pet and would be independent with taking her pet outside as needed. Review of R5's nursing notes identified staff observed the resident outside of the facility on the other side of the locked gate. They found her walker outside of the southeast door. On 06/20/23 at 08:50 AM Administrative staff A reported she was looking for the report but could not find one. On 06/20/23 at 01:00 PM administrative Licensed Nurse B reported she looked through the storage and could not find an investigation for when R5 was outside of the locked courtyard without staff knowing she had gone outside. Review of the report called to the hotline did not include information if the alarm sounded, if it was working at the time of the resident leaving the building or Review of the undated "Elopement" policy did not include information regarding the need to complete a thorough investigation and send to the department within 5 days. The executive director failed to thoroughly investigate and send completed investigation to the department within five working days when staff found R5 outside of the secured courtyard without her walker. - Review of R12's medical record revealed she moved into the facility on 01/06/23 with diagnosis of bipolar disorder, diabetes mellitus type II and psychotic disorder with delusions.	S3028		

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S3028	Continued From page 10 R12's combined "Functional Capacity Screen/ Negotiated Service Agreement" dated 03/17/22 identified the resident needed supervision with bathing and dressing and was independent with transfers and mobility. She had impaired cognition and wandering behaviors. Review R12's "Assisted Living Admission/Annual/Bi-Annual/Sig Change Assessment" dated 03/17/22 revealed the resident wandered and was easily distracted but did not exit seek and was not identified at risk for elopement. Review of the report called to the hotline on 07/11/22 revealed that on 06/25/22 R12 was found by staff out on the west side of the front parking lot. There was no additional investigation completed to identify when resident last seen, what may have happened to allow the resident to go out of the facility without staff knowledge. On 06/20/23 at 08:55 AM Administrative staff A reported she was still looking for the investigation but knew they thought R12 had followed another resident's family member out the front door during the fire watch. The executive director failed to report the resident being found outside of the facility without staff supervision within 24 hours and failed to thoroughly investigate how the resident got out of the facility and when the resident was last seen by facility staff during the fire watch procedures.	S3028		

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S3085	Continued From page 11	S3085		
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 43 residents with three residents included in the sample and seven closed record reviews. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 7 described the services he would receive based on his "Functional Capacity Screens" (FCS) for bathing, transfers, and falls and the services provided by a home health provider.	S3085		

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S3085	Continued From page 12 Findings included: - Record review for R7 revealed an admission date of 12/17/20 with a diagnosis of muscle weakness. The 12/17/20 "FCS" identified R7 required physical assistance with bathing, transfers, and was marked for falls. The 01/08/21 "NSA" failed to identify the services provided to R7 for bathing, transfers, and to prevent injury from falls. The "NSA" identified a home health provider but failed to identify the services they provided. The 04/22/21 facility's report to the department documented R7 was found on the floor beside his bed when they a meal tray to his room for breakfast which was served at 08:00 AM. The resident stated he fell at 06:00 AM and could not reach his call pendant to call for help. He had abrasions to both knees and the right side of his head and was transported to the hospital. On 06/21/23 at 12:55 PM Administrative Nurse B confirmed R7's "NSA" failed to describe the services he received based on his "FCS" for bathing, transfers, and falls. The facility's undated "Negotiated Service Agreement and Health Service Plan (NSA/HSP)" policy documented "The negotiated service agreement shall provide. . . a description of the services the resident will receive. . ." The administrator failed to ensure the "NSA" for R7 described the services he would receive	S3085		

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S3085	Continued From page 13 based on his "FCS" for bathing, transfers, and falls, and the services provided by a home health provider.	S3085		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure 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: KAR 26-41-202 (d)(2) The facility reported a census of 43 residents (R). The sample included three residents and one focused record review. Based on interview and record review the administrator failed to ensure staff reviewed and revised the combined "Functional Capacity Screen/Negotiated Service Agreement" if necessary, for two (R3 and R4) of three sampled residents who experienced a significant change in status related to initiation and discontinuation of therapy services and	S3092		

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S3092	Continued From page 14 home health services. Findings included: - On 06/20/23 at 07:14 PM Administrative Licensed Nurse B reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA) are one document. - Review of R3's medical record revealed she moved into the facility on 06/11/21 with diagnosis of dementia. R3's combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) dated 01/09/23 revealed the resident needed physician assistance with bathing, dressing, toileting and eating. She also had impaired cognition, impaired decision making and wandering. It included staff would assist the resident with activities of daily living. R3's electronic medical record did not include addendums or a revision to the FCS/NSA for when the resident received Speech Therapy from a local home health agency related to reoccurring emesis after meals. On 06/21/23 at 9:29 AM Administrative Licensed Nurse C acknowledged she now knew she needed to do an addendum for when someone started and stopped therapy services but had not ever done one. The executive director failed to ensure designated staff revised R3's FCS/NSA when she started and stopped speech therapy.	S3092		

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF SHAWNEE OPERATIONS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 16207 MIDLAND DRIVE SHAWNEE, KS 66217		
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S3092	Continued From page 15 - Review of R4's medical record revealed he moved into the facility on 02/28/23 with diagnosis of major depressive disorder, bipolar disease, and schizophrenia. R4's FCS/NSA dated 06/13/23 did not include the resident received wound care services from a local home health agency. The electronic record lacked addendums or revision for when he started and stopped physical therapy services and for when he started wound care services from a local home health agency. R4's electronic medical record revealed he started services for a local home health agency on 06/06/23 for wound care. He also received physical therapy from 07/26/22 to 01/23/23. On 06/21/23 at 9:29 AM Administrative Licensed Nurse C acknowledged there had not been addendums for the FCS/NSA for when the resident started on home health for wound care or for when he received physical therapy services. The executive director failed to ensure designated staff revised R4's FCS/NSA when he started and stopped physical therapy and wound care services from a local home health agency.	S3092			
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal	S3101			

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S3101	Continued From page 16 representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The facility reported a census of 43 residents (R). The sample included three residents and seven focused record reviews. Based on interview and record review for one (R5) of three sampled residents, the executive director failed to ensure that everyone involved in the development of the Negotiated Service Agreement signed the agreement. Findings included: - Review of R5's medical record revealed she moved into the facility on 01/09/20 with diagnoses of hypertension and epilepsy. R5's combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) dated 12/18/22 did not include the resident's signature. On 06/21/23 at 02:48 PM Administrative Licensed Nurse B had looked through the resident record and reported the resident signed her own paperwork and there was not a signed copy of the FCS/NSA for 12/18/22. The executive director failed to ensure all who participated in the development of R5's combined FCS/NSA signed it.	S3101		

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S3166	Continued From page 17	S3166		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 43 residents. Based on interview and record review the administrator failed to ensure all three of three sampled Certified Medication Aides (CMA) were trained and completed competencies for the delegated task of blood glucose checks for residents. Findings included: - Review of the CMA competency packets for staff revealed they did not include competencies for obtaining blood glucose checks for residents On 06/21/23 at 02:27 PM, Administrative Nurse B confirmed staff competency packets lacked evidence of documentation CMA's were able to obtain blood glucose checks for residents. The administrator failed to ensure designated staff completed competencies for the delegated task of blood glucose checks for residents.	S3166		

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S3171 SS=E	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 43 resident's (R). The sample included three residents and seven focused record reviews. Based on observation, interview, and record review the administrator failed to ensure that health care services were provided for two (R3 and R4) of three sampled residents in accordance with standards of practice regarding the assessment and safety of bed canes attached to each resident's bed used as an assistive device. Findings included: - Review of R3's medical record revealed she moved into the facility on 06/11/21 with diagnosis of dementia. Review of R3's combined "Functional Capacity Screen/Negotiated Service Agreement" (FCS/NSA) dated 01/09/23 did not include that she had an assistive device attached to the bed. R3's "Assisted Living Admission/Annual/Bi-Annual/Sig Change Assessment" also failed to identify that the resident had a bed assistive device in use.	S3171		

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S3171	Continued From page 19 Observation of on 06/19/23 at 01:11 PM revealed the resident had a Ubar on the open side of her bed. Surveyor was able to move the Ubar in any direction and it came clear out from under the mattress posing a risk for possible entrapment. On 06/21/23 at 11:15 AM Administrative Licensed Nurse C stated bed canes should be assessed for the resident's ability to use them and that they are secured to the bed. Nurse C looked at the Ubar on R3's bed and acknowledged the bar was not secured to the bed properly and had a large gap between the bars posing a possible risk for entrapment. Nurse C stated she did not think there was an assessment in the medical record for bed assistive devices. On 06/21/23 at 11:22 AM Administrative Licensed Nurse B acknowledged the Nurse assessment should have included the resident had a bed cane device marked and at that point an automatic assessment triggers for safety and resident ability to use. The operator failed to ensure designated staff assessed the safety and use of R3's Ubar attached to her bed. - Review of R4's medical record revealed he moved into the facility on 0228/23 with diagnoses of anxiety disorder and schizophrenia. R4's combined "Functional Capacity Screen/Negotiated Service Agreement" dated 06/13/23 identified the resident had a bed cane assistive device.	S3171		

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S3171	Continued From page 20 R4's "Assisted Living Admission/Annual/Bi-Annual/Sig Change Assessment" failed to identify that the resident had a bed assistive device in use. Observation on 06/19/23 at 01:23 PM the resident lay in his bed on on the left side of the bed was a bed cane device. R4 stated he used it all the time to help reposition in bed. The bed assistive device was secured to the bed but had a large gap between the bars of the device. On 06/21/23 at 11:15 AM Administrative Licensed Nurse C stated bed canes should be assessed for the resident's ability to use them and that they are secured to the bed. Nurse C stated she did not think there was an assessment in the medical record for bed assistive devices. On 06/21/23 at 11:22 AM Administrative Licensed Nurse B acknowledged the Nurse assessment should have included the resident had a bed cane device marked and at that point an automatic assessment triggers for safety and resident ability to use. The operator failed to ensure designated staff assessed the safety and use of R3's assistive device attached to his bed.	S3171		
S3201 SS=D	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the	S3201		

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S3201	Continued From page 21 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)(D) The facility reported a census of 43 residents. The Sample included three residents and seven focused record reviews. Based on interview, and record review the operator failed to ensure facility staff followed professional standards of practice while administering medications for 1 (R4) of three sampled residents by the failure of the medication aides to document the administration of each resident's medication in the medications administration record immediately before or following the completion of the task. Findings included: - On 06/20/23 at 07:14 PM Administrative	S3201		

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S3201	Continued From page 22 Licensed Nurse B reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA) are one document. - Review of R4's medical record revealed he moved into the facility on 02/28/23 with diagnosis of major depressive disorder, bipolar disease, and schizophrenia. R4's FCS/NSA dated 06/13/23 revealed the resident was unable to manage his medications or medical treatments and the staff nurse prepared and administered the resident's medications. Review of R4's June 2023 Medication Administration Record (MAR) revealed staff failed to document the administration of the following medications the evening of 06/19/23: Melatonin, Tamsulosin, Zoloft (antidepressant), Zyprexa (antipsychotic), Haloperidol (antipsychotic), Aldactone (diuretic), Budesonide Suspension, Colace, Demadex (diuretic), Depakote (anticonvulsant), Potassium Chloride, DuoNeb solution, and Diclofenac Sodium Gel (pain). Staff also failed to document the administration of R4's Budesonide Suspension for 0600 on the 1st, 2nd, 3rd, 4th, 6th, 7th, 13th, 14th, 15th, 16th, 17th, and 19th. On 06/20/23 at 01:00 PM Certified Medication Aide (CMA) I reported when the CMA passed a residents medication, they were supposed to get it ready, press yes, give the medication and then click on save so the electronic record will initial the medication as administered. She stated if a	S3201		

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S3201	Continued From page 23 medication is not initialed as administered, it will turn red and the CMA is supposed to address it. On 06/21/23 at 01:09 PM Administrative Licensed Nurse C reported the policy is there are not to be any holes in the MAR, and we just had an in-service on staff needing to make sure they are documenting the administration of medications. The operator failed to ensure medications that were the responsibility of the facility to manage and administer, were administered to R4 according to professional standards of practice.	S3201		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 43 residents. Based on interview and record review the administrator failed to ensure all three of three sampled Certified Medication Aides (CMA) were trained and completed competencies for delegated insulin pen preparation for residents to self-administer. Findings included:	S3202		

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S3202	Continued From page 24 - Review of the CMA competency packets for staff revealed they did not include competencies for preparing insulin for resident self-administration. On 06/21/23 at 02:27 PM, Administrative Nurse B confirmed staff competency packets lacked evidence of documentation for preparing insulin pens for resident self-administration. The administrator failed to ensure designated staff completed competencies for Certified Medication Aides to prepare insulin pens for residents to be able to self-inject.	S3202		
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 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 43 residents (R). The sample included three residents and seven focused record reviews. Based on interview and record review the operator failed to ensure each resident record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was	S3261		

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S3261	Continued From page 25 done, and the results of action taken for three (R3, R4, R5) of three sampled residents. Findings included: - On 06/20/23 at 07:14 PM Administrative Licensed Nurse B reported the "Functional Capacity Screen" and the "Negotiated Service Agreement" (FCS/NSA) are one document. - Review of R3's medical record revealed she moved into the facility on 06/11/21 with diagnosis of dementia. R3's combined "Functional Capacity Screen/Negotiated Service Agreement" dated 01/09/23 revealed the resident needed physician assistance with bathing, dressing, toileting and eating. She also had impaired cognition, impaired decision making and wandering. It included staff would assist the resident with activities of daily living. R3's "Service Plan" included the resident required cueing and supervision with daily cares. R3's electronic record included the following nursing progress notes: 03/02/23 - resident acting very aggression Urine Analysis (UA) obtained urine yellow and cloudy and sent to lab. The record lacked follow up on the results of the UA. 03/09/23 - resident was found sitting on the floor in the middle of the night and staff contacted emergency medical services who did not identify concerns for emergency room evaluation. When staff tried to walk the resident down to dinning	S3261		

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S3261	Continued From page 26 room for breakfast - resident had pain with walking. Medical provider contacted and ordered stat hip x-rays. The record lacked follow-up on if the x-rays were obtained and the results. On 06/21/23 at 09:36 AM Administrative Licensed Nurse C stated the nurse documentation needed to include any changes in the resident condition and any complaints of pain or illness. Nurse C stated she would have expected there to be documentation for follow up on the UA and the X-ray results. The executive director failed to ensure designated staff documented in R3's record follow up related to UA and x-ray results. - Review of R4's medical record revealed he moved into the facility on 02/28/23 with diagnosis of major depressive disorder, bipolar disease, and schizophrenia. R4's FCS/NSA dated 06/13/23 revealed the resident required assistance with all activities of daily living, had impaired cognition and had a current problem or was at risk for falls. It identified staff would assist with activities of daily living. R4's "Service Plan" included interventions related to fall risk as well as cueing and specific assistance needed with activities of daily living. Review of R4's electronic record included the following nursing progress notes: 8/3/2022 - Resident returned from local hospital emergency room.	S3261		

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S3261	Continued From page 27 The record lacked documentation as to the resident going to the emergency room or why he went. 09/02/22 - Resident will be going to a skilled nursing facility for rehab. The record lacked documentation of the resident returning to the facility and assessment of resident upon his return. 02/19/23 - Resident sent to local hospital for evaluation status post fall. The record lacked documentation of the resident returning from the emergency room. 04/29/23 - resident on the floor stated he hit his head and yelled when stood up. Medical provider contacted and instructed to send to the emergency room. The record lacked documentation if the resident went to the emergency room and status upon return to the facility. 05/02/23 - the resident found on the floor beside his bed. The record lacked follow up on the resident's status post fall. On 06/21/23 at 09:36 AM Administrative Licensed Nurse C stated the nurse documentation needed to include any changes in the resident condition and any complaints of pain or illness. Nurse C acknowledged the nursing documentation lacked follow up documentation as she would expect. The executive director failed to ensure designated staff documented in R4's record regarding fall follow-up and emergency room / hospitalization follow up. - Review of R5's medical record revealed she	S3261			

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S3261	Continued From page 28 moved into the facility on 01/09/20 with diagnoses of hypertension, major depressive disorder, and epilepsy. Review of R5's combined "Functional Capacity Screen/Negotiated Service Agreement" dated 12/18/22 revealed the resident needed physical assistance with bathing, dressing, toileting, and with management of medications. Review of R5's electronic medical record nursing progress notes revealed the following: 6/24/2022 - Nurse spoke with medical provider and got orders to schedule the residents Haloperidol (antipsychotic) to see if reduce the residents' hallucinations and decrease her trying to exit the facility. The record lacked follow up as to the effectiveness of the medication change in relation to the residents' hallucinations and trying to leave the facility. 12/08/22 - Resident with low oxygen saturation and medical provider wanted resident sent to the emergency room for evaluation. The record lacked documentation of the resident's return to the facility and status upon return. 05/15/23 - resident complained of chest pain and transferred to the emergency room via emergency medical services. The record lacked follow-up on the residents return and symptoms of chest pain. On 06/21/23 at 09:36 AM Administrative Licensed Nurse C stated the nurse documentation needed to include any changes in the resident condition and any complaints of pain or illness. Nurse C acknowledged the nursing	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF SHAWNEE OPERATIONS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16207 MIDLAND DRIVE SHAWNEE, KS 66217		
(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 documentation lacked follow up documentation as she would expect. The executive director failed to ensure designated staff documented in R4's record regarding follow-up to changes to antipsychotic medication, and hospitalizations.	S3261		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 43 residents. Based on interview and record review the operator failed to provide quarterly reviews of the	S3280		

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S3280	Continued From page 30 facility's emergency management plan with staff and residents. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation of quarterly reviews with staff during the fourth quarter of 2022 and with residents during the second and fourth quarter of 2022. On 06/19/23 at 12:33 PM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with staff and residents. The administrator failed to provide quarterly reviews of the facility's emergency management plan with staff and residents.	S3280		
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	S3310		

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S3310	Continued From page 31 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 43 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: - License Nurse C's employee record revealed a hire date of 11/14/22. The employee record lacked evidence of documentation a TB test was completed within seven days of hire. Certified Medication Aide (CMA) D's employee record revealed a hire date of 11/04/21. The employee record lacked evidence of documentation a TB symptoms screen was completed within 7 days of hire. CMA E's employee record revealed a hire date of 08/14/21. The employee record lacked evidence of documentation a TB test was completed within 7 days of hire. CMA F's employee record revealed a hire date of 04/27/23. The employee record lacked evidence of documentation a TB symptom screen was completed within 7 days of hire and the second step TB skin test results were not read.	S3310		

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S3310	Continued From page 32 Dietary Staff G's employee record revealed a hire date of 03/15/22. The employee record lacked evidence of documentation a TB symptom screen was completed within 7 days of hire. The department's June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented "Each new employee shall have an initial TB symptom screen. . . within seven days of employment. . . Each new employee shall receive a two-step TST. . . within seven days of residency or employment." On 06/21/23 at 08:37 PM Administrative Nurse B confirmed staff records lacked evidence of documentation TB testing and symptom screens according to the department's tuberculosis guidelines. 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		