

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/19/2023
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10101 W 127TH ST OVERLAND PARK, KS 66213		
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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey for the above named Assisted Living Facility with complaint investigations 169927, 170885, 173292, 173805, 175705, 175779, 176281, 176395, 177644, and 181260 conducted on 07/18/23 and 07/19/23.	S 000		
S3026 SS=D	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 53 residents (R). The sample included three residents and five focused record reviews. Based on interview, and record review for one (R8) of five focused reviews the executive director failed to ensure staff responded promptly when notified a resident had left the facility unsupervised to be with the resident to ensure his safety. Findings included: - Review of R8's medical record revealed he	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 moved into the facility on 07.08/22 with diagnosis of dementia. R8's "Functional Capacity Screen" dated 08/19/22 revealed the resident was independent with transfers and mobility. He also had significantly impaired cognition, communication difficulties, was at risk for falls, had inappropriate behaviors as well as wandering behaviors. On 07/18/23 at 03:42 PM Administrative Licensed Nurse B stated the "Negotiated Service Agreement" and the "Health Care Service Plan" were one document (NSA/HCSP). R8's NSA/HCSP dated 08/19/22 directed staff to provide redirection, cueing, reminders, validate when looking for wife, and allow time for him to find his words while providing cares. I identified the resident wandered occasionally and indiscriminately often looking for his wife. Staff needed to engage resident in activities to help reduce boredom and wandering. Review of R8's nursing notes revealed on 11/24/22 Certified Medication Aide (CMA) D worked in House 3 and heard the alarm go off for House 3 and R8 stood outside. CMA D notified the licensed nurse and then escorted the resident back to House 2. Review of the facility report revealed Administration reviewed the wander guard system and the door to House 2 was opened at 1232. A maintenance tech observed the resident walking in the parking lot but was not for sure if he was a resident. He went into House 2 and staff were not at the front wellness center or	S3026		

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S3026	Continued From page 2 dining room, so he went to the receptionist in House 1 and told her he thought a resident was outside walking in the parking lot. At that point the receptionist told maintenance staff to report it to the manager on duty, which he did. Neither the maintenance staff nor the receptionist went to stay with the resident to ensure his safety. All staff in House 2 denied hearing the wanderguard alarm go off so it was determined that CMA E accidentally allowed the resident to go out of the facility when she put in the code for visiting family members to leave. Observation on 07/18/23 at 01:45 PM resident had family visiting in the room with him. At 02:15 PM he walked out the main front living room area with family and sat on the couch. When his family started to leave, and he got up from the couch wanting to go with them. Staff intervened and had him wave to family and reassured him his wife would be back tomorrow. Observation on 07/19/23 at 11:00 AM surveyor came out of another resident room and R8 stood at the side exit door pushing on the bar with the alarm sounding. CMA F walked down the hall toward the resident and called out to him asking what he was doing. The resident turned around and headed toward the CMA. The CMA turned off the alarm and the resident walked to the dining room with the CMA. On 07/18/23 at 03:57 PM Administrative Licensed Nurse B acknowledged the maintenance staff should have gone to the resident to bring back into a house and the receptionist also should have gone out to the parking lot when she was told a resident was in	S3026		

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S3026	Continued From page 3 the parking lot. On 07/19/23 at 6:25 AM Certified CMA G reported that if any alarm goes off, we are to hurry to the alarm and see what is going on. If it is a door alarm, we go to that door and hurry and then first look outside and if not see anyone we then go outside and call someone from the other house to help us to look to see if someone went outside. When we see a resident outside, we need to go get them and redirect them back into the building. The executive director failed to ensure that staff responded appropriately when a resident was identified out in the parking lot.	S3026		
S3085 SS=F	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.	S3085		

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S3085	Continued From page 4 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 53 resident (R)s. The sample included three residents and five focused record reviews. Based on interview and record review for all residents identified at risk for elopement, including two (R3 and R4) of three sampled residents and one (R8) of five focused reviews, the executive director failed to ensure the Negotiated Service Agreement contained a description of the health care services of wearing a wanderguard to be provided related to risk for elopement. Findings included: - On 07/18/23 Administrative Licensed Nurse provided a list of all residents identified as risk for elopement. The list included 33 residents and Administrative Licensed Nurse stated all residents at risk for elopement wore some type of wanderguard, either on their wrist or ankle. Review of R3's medical record revealed she moved into the facility on 01/04/21 with diagnosis of Alzheimer's disease. R3's "Functional Capacity Screen" dated 01/04/23 revealed the resident had impaired cognition, impaired decision making and wandering behaviors. On 07/18/23 at 03:42 PM Administrative Licensed Nurse B reported the "negotiated	S3085		

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S3085	Continued From page 5 Service Agreement" and the "Health Care Service Plan" are one document (NSA/HCSP). Review of R3's NSA/HCSP identified the resident had impaired cognition and wandered throughout the facility but failed to include the use of a wanderguard to help prevent elopement. On 07/18/23 at 04:12 PM Administrative Licensed Nurse B stated she did not include the wanderguards in any of the residents NSA/HCSP who wore them. The Executive director failed to ensure the NSA/HCSP included the use of a wanderguard to help prevent risk of elopement. - Review of R4's medical record revealed he moved into the facility on 10/26/22 with diagnosis of Alzheimer's Dementia. R4's "Functional Capacity Screen" dated 04/24/23 revealed the resident had impaired cognition, impaired decision making and wandering behaviors. On 07/18/23 at 03:42 PM Administrative Licensed Nurse B reported the "negotiated Service Agreement" and the "Health Care Service Plan" are one document (NSA/HCSP). Review of R4's NSA/HCSP identified the resident had impaired cognition and wandered throughout the facility but failed to include the use of a wanderguard to help prevent elopement. On 07/18/23 at 04:12 PM Administrative Licensed Nurse B stated she did not include the	S3085		

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S3085	Continued From page 6 wanderguards in any of the residents NSA/HCSF who wore them The Executive director failed to ensure the NSA/HCSF included the use of a wanderguard to help prevent risk of elopement. - Review of R8's medical record revealed he moved into the facility on 07/08/22 with diagnoses of dementia. R8's "Functional Capacity Screen" identified the resident walked and transferred with staff supervision, had impaired cognition, inappropriate behaviors and wandering. On 07/18/23 at 03:42 PM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" are one document (NSA/HCSF). Review of R8's NSA/HCSF identified the resident wandered, had impaired judgement and lack of safety awareness but failed to include the use of a wanderguard to help prevent elopement. On 07/18/23 at 04:12 PM Administrative Licensed Nurse B stated she did not include the wanderguards in any of the residents NSA/HCSF who wore them. For all residents who wore a wanderguard, the executive director failed to ensure the NSA/HCSF included the use of a wanderguard to help prevent risk of elopement.	S3085		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS	S3211		

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S3211	Continued From page 7 (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 53 residents. Based on observation and interview, the executive director failed to ensure all over-the-counter medications were labeled with the resident's full name. This includes the need for the resident's full name to be on the original manufacturer's medication package and the medication container/insert. Findings included: - During initial tour of the facility on 07/18/23 at 09:05 AM Certified Medication Aide (CMA) C opened the Memory for House A (one) which revealed the following over-the -counter medications without a residents full name on them: generic gas relief tablets, Vitamin D3, Dry	S3211		

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S3211	Continued From page 8 eye relief dropps, gold bond medicated powder. On 07/18/23 at 9:06 AM CMA C acknowledged some of the over-the-counter medications did not have the residnets full name on the container. On 09:09 AM Administrative Staff A acknowledged over-the-counter medications needed to have the residents full name on the container. The executive director failed to ensure all over-the-counter medications included the full name of the resident they belonged to and included the name on the original manufacturer's medication package and the medication container.	S3211		
S3270 SS=E	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	S3270		

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S3270	Continued From page 9 by: KAR 26-41-104(b)(2)(5) The facility reported a census of 53 residents in assisted living. Based on interview and record review the executive director failed to ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters that include a plan for flood or explosion. Findings included: - Review of the emergency management plan notebook in House 3 lacked an emergency plan for potential of floods - or explosion. On 07/18/23 at 12:54 PM Administrative Staff A looked through the emergency plan notebook and questioned if it was complete. On 07/19/23 at 01:05 PM Administrative staff acknowledged the facility's emergency management plan did not include explosion or flood. The executive director failed to ensure the development of detailed written Emergency Management Plan that included what to do incase of a flood or explosion.	S3270		
S3280 SS=F	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	S3280		

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S3280	Continued From page 10 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 53 residents. Based on interview and record review the executive director failed to provide disaster preparedness by the failure to complete quarterly reviews of the facility's emergency management plan with staff and residents. Findings included: - On 07/18/23 at 11:41 AM, review of the staff in-services provided by Administrative Staff A included an in-service with part of the agenda "facility emergency plan" review that was done in February, May, and November of 2022 and in May of 2023. The information lacked what was reviewed and it was not reviewed quarterly as required.	S3280		

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S3280	Continued From page 11 On 07/18/23 at 12:45 PM Administrative Staff A reported they emergency plan is supposed to be reviewed quarterly during in-services. She reviewed the in-services provided and said she would look to see if there were additional information for staff in-services. No additional information was provided. On 07/18/23 at 01:05 PM Administrative Staff A stated she could not find the resident council book and that is were information would have been regarding the review of the emergency plan with residents. Review of the undated "Disaster Policy Review" revealed the staff will know and practice disaster procedures through regular drills and review. Residents will be informed of disaster procedures quarterly to ensure they are knowledgeable on the protocols related to disasters. The Executive Director failed to conduct quarterly reviews of the facility's emergency management plan with staff and residents.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects,	S3298		

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S3298	Continued From page 12 including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 53 residents. Based on record review and interview, the executive director failed to ensure staff prepared and served food at the proper temperature. Findings included: - During initial tour on 07/18/23 at 9:24 AM Dietary Staff I reported all the food is prepared in the main kitchen in house 2 and then transported to the houses in a hot cart and put on the steam table. During initial tour of each house on 07/18/23 revealed the following: House 1: The food temperature log had multiple days in April, May, June, and July without food temperatures taken. House 2: The food temperature log had multiple holes in the months of April, May, and June. The	S3298		

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S3298	Continued From page 13 last date a food temperature was taken was 06/15/23. House 3: The food temp log had multiple days for April and May without food temperatures taken. The month of June had one meal food temperature and July had one day written down but it did not include food temperatures. On 07/18/23 at 10:57 AM Dietary staff J reported after the food is taken to each house and is located on the steam table. The staff are supposed to check the temperature of each hot item to ensure it is served at the proper temperature. Review of the "Monitoring Food Temperatures for Meal Service" policy and procedure revealed staff were to take the temperature of all hot and cold foods prior to serving to ensure proper serving temperatures. The executive director failed to ensure dietary staff monitored food cooking and serving temperatures to ensure it was prepared and served at the proper temperature.	S3298		
S3310 SS=E	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	S3310		

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S3310	Continued From page 14 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) The facility reported a census of 53 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 two of five newly hired staff. Findings included: - Certified Medication Aide (CMA) H's employee record revealed a hire date of 05/01/23. The employee record revealed she completed a TB symptom screen on 05/16/23, 15 days after hire date. She also received her first TB skin test 15 days after hire date. CMA I's employee record revealed a hire date of 03/22/23 with a start date of 04/05/23. The employee record revealed she did not receive her first TB skin test until 05/07/23, 32 days after her hired date. The department's June 2013 "Tuberculosis (TB) Guidelines for Adult Care Homes" documented	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/19/2023
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10101 W 127TH ST OVERLAND PARK, KS 66213		
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S3310	Continued From page 15 "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 07/18/23 at 12:16 PM Administrative Licensed Nurse B stated she knew some did not get done right away because they work nights or something and they tried to get them done within the first two week of employment. 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		