

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/11/2023
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 6921 W 81ST STREET OVERLAND PARK, KS 66204		
(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 represent the findings of a complaint investigation #182672 at the above named assisted living conducted on 09/11/23.	S 000		
S 135 SS=D	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)(A) The facility reported a census of 65 residents	S 135		

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

TITLE

(X6) DATE

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S 135	Continued From page 1 with one resident sampled for abbreviated review. Based on interview and record review the administrator failed to ensure licensed staff notified legal representatives or designated family members when Resident (R) 1 developed facial and shoulder bruising after an unwitnessed fall. Findings included: - Record review R1 revealed an admission date of 06/30/22 with diagnoses of Alzheimer's disease, dementia, history of falling, unsteadiness on feet, muscle weakness, and lack of coordination. The 06/30/23 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing; supervision for transfers and walking/mobility; and had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties. The 06/30/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide R 1 physical assistance entering and exiting bath; supervision with transfers; she used a walker at all times with walking/mobility; and staff monitored for presence of an alert bracelet for cognitive difficulties. The 08/21/23 provider's visit note documented R1 was seen for a reported fall that morning. R1 had a contusion and hematoma to the right side of her forehead, pain and abrasion to her right shoulder with swelling. The 08/21/23 "Physician Telephone Order"	S 135		

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S 135	Continued From page 2 documented orders for a mobile x-ray to right shoulder. The 08/31/23 (10 days after the fall) "Alert Charting" progress note by Licensed Nurse B documented R1's unidentified family member called and was shocked to see bruising on R1's face and shoulder. The family member was upset because no one from the facility had notified her about the bruising. R1's record lacked evidence of documentation by licensed nursing staff that her legal representative or designated family member was notified when she developed facial and shoulder bruising after an unwitnessed fall. On 09/11/23 at approximately 12:26 PM License Nurse B confirmed R1's records lacked evidence of documentation that her legal representative or designated family members were notified when she developed facial and shoulder bruising after an unwitnessed fall. On 09/11/23 at approximately 01:49 PM Administrative Nurse A confirmed R1's records lacked evidence of documentation that her legal representative or designated family members were notified when she developed facial and shoulder bruising after an unwitnessed fall. The administrator failed to ensure licensed staff notified legal representatives or designated family members when R1 developed facial and shoulder bruising after an unwitnessed fall.	S 135		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

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S3261	Continued From page 3 (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 65 residents with one resident sampled for abbreviated review. Based on interview and record review the administrator failed to ensure licensed staff documented when Resident (R) 1 developed facial and shoulder bruising after an unwitnessed fall. Findings included: - Record review R1 revealed an admission date of 06/30/22 with diagnoses of Alzheimer's disease, dementia, history of falling, unsteadiness on feet, muscle weakness, and lack of coordination. The 06/30/23 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with bathing; supervision for transfers and walking/mobility; and had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties. The 06/30/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide R1	S3261		

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S3261	Continued From page 4 physical assistance entering and exiting bath; supervision with transfers; she used a walker at all times with walking/mobility; and staff monitored for presence of an alert bracelet for cognitive difficulties. The 08/21/23 provider's visit note documented R1 was seen for a reported fall that morning. R1 had a contusion and hematoma to the right side of her forehead, pain and abrasion to her right shoulder with swelling. The 08/21/23 "Physician Telephone Order" documented orders for a mobile x-ray to right shoulder. The 08/31/23 (10 days after the fall) "Alert Charting" progress note by Licensed Nurse B documented R1's unidentified family member called and was shocked to see bruising on R1's face and shoulder. The family member was upset because no one from the facility had notified her about the bruising. Review of R1's record from 06/21/23 to 09/11/23 revealed lack of evidence of documentation of R1's unwitnessed fall with injuries; nursing assessment/vital signs after the fall including fall follow-up charting; notification of physician and R1's family; fall investigation; interventions to prevent falls/injury from falls; and results of interventions. On 09/11/23 at approximately 01:49 PM Administrative Nurse A confirmed R1's record lacked evidence of documentation after the fall on 08/21/23.	S3261		

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S3261	Continued From page 5 The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action taken when Resident (R) 1 developed facial and shoulder bruising after an unwitnessed fall.	S3261		