

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2024
NAME OF PROVIDER OR SUPPLIER SILVERCREST AT DEER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 13060 METCALF AVENUE OVERLAND PARK, KS 66213		
(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 the licensure resurvey with attached complaint numbers 180225, 180179, and 180114, for the above named facility conducted on 01/30/24.	S 000		
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 representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 30 residents. The sample included residents and focused review. Based on observation, interview and record review the Operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) R1 was signed by all participants in the development of the NSA. Findings included: - Record review for R1 revealed an admission date of 01/13/22 with diagnoses of chronic kidney disease stage 3, anxiety, and arthritis. Record review of R1's unsigned combined "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) revealed the facility would provide R1 with physical assistance of one person with bathing	S3101		

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

TITLE

(X6) DATE

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S3101	Continued From page 1 and dressing, physical assist with medication management, fall interventions including ensuring R1 wore appropriate footwear and provide clutter free environment. He was able to make himself understood and he understood others, was cognitive intact and used a walker mobility device independently. Record review of R1's electronic medical record under the "Progress Note" tab revealed on 11/10/23 at 12:59AM "Kansas Health and Function change of condition assessment completed by this nurse, son will come in next week to sign." Interviewed Administrative Nurse B on 01/30/23 at 03:00PM who confirmed the combined NSA/FCS/HSP dated 11/10/23 lacked all participants signatures. The 11/10/23 combined FCS/NSA/HSP document lacked that all participants signed the agreement. The operator failed to ensure the combined document NSA/FCS/HSP for R1 was signed by all participants.	S3101		
S3211 SS=E	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	S3211		

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S3211	Continued From page 2 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: K.A.R. 26-41-205 (g)(3) The facility reported a census of 30 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist, or a "Licensed Nurse" (LN) placed the full name of the resident on the "Over the counter" (OTC) medications. Findings included: - Observation during the facility tour on 01/30/24 at 11:00 AM "Certified Medication Aide" (CMA) A opened the locked medication cart labeled "Cart 1" and in the third drawer revealed the following unlabeled medications: 1 bottle of Top Care Vegetable Laxative. 1 bottle of Top Care Pain Relief 325 Milligrams. CMA A then unlocked the locked medication cart labeled "Cart 2" and in the first drawer down revealed the following unlabeled OTC: 1 bottle of Fluticasone Spray 50 micro grams In the bottom drawer of medication "Cart 2" was a bottle of Peppermint Calcium Chews Anti Acid labeled "Stock". Interview on 01/30/24 at 11:10 AM with LN B confirmed the OTC medications are to be labeled	S3211		

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S3211	Continued From page 3 with the resident full name and she continued the facility is not to use "Stock" medications. The operator failed to ensure a licensed pharmacist, or a "Licensed Nurse" (LN) placed the full name of the resident on the "Over the counter" (OTC) medications.	S3211		
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: K.A.R. 26-41-105 (f) (11) The facility reported a census of 30 residents. The sample included Residents (R) 1, R2, and R3. Based on interview and record review the operator failed to ensure the resident records contained the documentation of all incidents, other indications of illness or injury, actions taken, and results of the actions taken for R1, R2, and R3. Findings included: - Record review for R1 revealed an admission date of 01/13/22 with diagnoses of chronic kidney disease stage 3, anxiety, and arthritis. Record review of R1's unsigned combined	S3261		

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S3261	Continued From page 4 "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) revealed the facility would provide R1 with physical assistance of one person with bathing and dressing, physical assistance with medication management, fall interventions including ensuring R1 wore appropriate footwear and provide clutter free environment. He was able to make himself understood and he understood others, was cognitive intact and used a walker mobility device independently. Record review of R1's electronic medical record under the "Progress Note" tab revealed the following entry: 11/10/23 at 12:59 AM "Kansas Health and Function change of condition assessment completed by this nurse, son will come in next week to sign." 11/15/23 at 05:42 PM "resident remains to have increase confusion, new order for nitrofurantoin 100mg BID X 7 days." The document lacked the documentation for the results of actions taken for the antibiotic and increased confusion. 01/5/24 at 01:47 PM "resident lungs are wet and crackles throughout, new order for chest xray 2 views. Omnicef 300mg BID X 5 days, Prednisone taper dose, 40mg X 3 days, 30 X 1 day, 20 x 1 day, 10 x 1 day then D/C. Resident negative for COVID." The document lacked the documentation for the results of actions taken for antibiotic and results of xray. 01/19/24 at 10:10 AM "Resident pulled call light cord in bathroom for assistance, when staff arrived he was seated on the floor with back against the wall. Resident stated was trying to	S3261		

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S3261	Continued From page 5 use the bathroom by himself and when transferring off the toilet he lost his balance and fell against the wall and slid down. Resident has small skin tear on right finger and right knee, has bruising on right hand. VS taken 122/75, 97, 22, 97.1 Nurse notified." 01/19/24 at 04:01 PM "resident alert & O, resident expressed he was transferring from the toilet and lost his balance, resident denies pain at this time. Resident educated on his call pendant, how to use it and keep it on the outside of the shirt, resident expressed his understanding." The document lacked documentation for the actions taken after the resident for fell. Interviewed Administrative Nurse B on 01/30/23 at 05:11 PM who confirmed the documentation lacked follow up for actions taken and results for actions taken for when R1 exhibited signs/ symptoms of an illness and after an incident of a fall. - Record review for R2 revealed an admission date of 12/04/18 with diagnoses of benign neoplasm of the renal pelvis, chronic diastolic congestive heart failure, chronic kidney disease stage 3, chronic obstructive pulmonary disease, and other depressive episodes. Record review of R2's combined "Functional Capacity Screen" (FCS)/ "Negotiated Service Agreement" (NSA)/" Health Service Plan" (HSP) revealed/identified the following resident functional capacity and health services the facility would provide R2 with physical assistance of one person with bathing and dressing, fall interventions included ensuring R2 wore appropriate footwear and asking for assistance when needed. She was able to make herself	S3261		

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S3261	Continued From page 6 understood and she understood others, she was cognitively intact and used a walker/scooter mobility device. Review of R2's electronic medical record under the "Progress Notes" tab revealed the following entries: 08/04/23 at 11:45 AM R2 called at 07:45 PM, staff responded and found R2 sitting on the floor in her bathroom. R2 stated she felt "dizzy and fell backward". Staff obtained vital signs and "reminded resident to be careful". The next entry was dated 08/15/22 stating R2 had been seen by the podiatrist. The document lacked actions taken for resident reporting dizziness, which caused her to fall and interventions to monitor R2 after her fall. 12/24/23 at 04:08 PM "Resident had a non-injury fall, staff called daughter, and left message for doctor", nurse will follow up when she returned to work on "Thursday". 12/28/23 at 10:22 AM at 10:22 AM "Resident had a non-injury fall on 12/24/23" She denied pain and stated she "lost her balance", no injuries were reported. 12/28/23 at 10:27 AM at 07:20 PM the nurse was notified by facility CMA that she observed R2 "standing talking, then observed resident going backwards on her bottom". The CMA then asked R2 if she was hurt and R2 responded she was not hurt. The CMA called the facility nurse and obtained vital signs. The document lacked an entry for actions taken to monitor R2 after she fell with no noted cause.	S3261		

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S3261	Continued From page 7 Interview on 01/20/24 at 05:11 PM with "Licensed Nurse" (LN) B confirmed the "Progress Notes" for R2 lacked documentation of actions taken and results of the actions after three documented falls. - Record review for R3 revealed an admission date of 05/18/21 with diagnoses of diabetes mellitus due to underlying condition, hypertensive crises, convulsions, Vitamin B12 anemia, acute kidney failure, cognitive impairment, and generalized muscle weakness. Record review of R3's combined FCS/ NSA/HSP revealed/identified the following resident functional capacity and health services the facility would provide R3 with supervision and cues to change her clothing, and physical assistance with managing her mediations. She was incontinent of her bladder and was independent with her toileting. Fall interventions for R3 included staff to ensure she wore appropriate footwear and asking for assistance when needed. She was able to make herself understood and she understood others, was cognitively intact and used a walker mobility device. Review of R3's electronic medical record under the "Progress Note" tab revealed the following entries: 01/29/24 at 10:57 AM "Resident had a fall over the weekend, resident has no open areas". 01/29/24 at 10:53 AM R3 activated her call light at 05:54 AM and responding staff found R3 sitting on the floor in her bathroom. R3 told staff she woke up and picked out her clothes for the day and then went into the bathroom. She lost her	S3261		

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S3261	Continued From page 8 balance near the bathroom door and fell backward in a sitting position. R3 was advised not to dress herself, but wait for staff to come and help her. 11/26/23 at 04:32 PM "Resident had a non-injury fall on 11/23/23. R3 was observed as alert and denied pain. The nurse "encouraged resident to use call light before getting up so staff could assist her". 11/26/23 at 04:29 PM "Resident was found laying on a basket of towels on the bathroom floor". R3 stated she fell while trying to get to the toilet. 11/13/23 at 01:58 PM "Resident had an assisted fall yesterday". Fall was related to "Weakness". 11/13/23 at 01:41 PM R3 was in her bathroom with her walker. R3 was found trying to open the bathroom door. R3 was unsteady and lost her balance. The document lacked entries for actions taken to monitor R3 after her falls and further lacked actions taken on R3 having fell related to weakness and unsteady gait. Interview on 01/20/24 at 05:11 PM with "Licensed Nurse" (LN) B confirmed the "Progress Notes" for R3 lacked documentation of actions taken and results of the actions after six documented falls. The operator failed to ensure the resident records contained the documentation of all incidents, other indications of illness or injury, actions taken, and results of the actions taken for R1, R2, and R3.	S3261		