STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175281	A. BUILDING _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KANSAS CITY	3231 N 61ST STREET KANSAS CITY, KS 66104

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00185531 and KS00185685. The 2567 was sent electronically on 02/29/24.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 69 residents. The sample included three residents. Based on record review, interview, and observation the facility failed to accommodate Resident (R) 1's need and preference for a transfer pole This placed R1 at risk of decreased mobility and impaired autonomy. Findings included: - R1's Electronic Medical Record (EMR), under the "Diagnosis" tab recorded diagnoses of hemiplegia (paralysis of one side of the body), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), muscle weakness, need for assistance with personal care, and major	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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depressive disorder (major mood disorder which causes persistent feelings of sadness).

R1's "Admission Minimum Data Set" (MDS) dated 11/02/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required supervision, verbal cues, or touching to help steady R1 during any form of mobility. R1 was independent with wheelchair mobility of at least 50 feet and making two turns.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 11/02/23 documented R1 was alert and oriented and communicated needs. R1 used a wheelchair for locomotion and required minimal assistance with ADLs.

R1's "Care Plan" initiated on 10/27/23 directed staff to encourage R1 to participate to the fullest extent possible with each interaction.

R1's "Care Plan" lacked direction on how R1 transferred, or assistance required.

R1's "Physical Therapy Evaluation and Plan of Treatment" dated 10/25/23 documented R1 reported he used a transfer pole at his prior facility and was independent at baseline with a transfer pole. This treatment plan note documented the information was communicated to nursing staff and therapy asked about ordering and installing a transfer pole for R1.

The "Progress Note" dated 01/25/24 at 02:39 PM documented a transfer pole was properly installed into R1's room, secured at both the ceiling and the floor. The transfer pole was assessed by Consultant HH and determined to be unstable; specifically, the middle of the pole was not safe to

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use for transfers.

R1's EMR lacked any other documentation about a transfer pole.

On 02/22/24 at 12:30 PM, Consultant GG stated to order equipment for residents, she went to Administrative Staff A or Administrative Nurse D. Consultant GG stated that if equipment had to be installed, facility maintenance would take care of that. Consultant GG revealed she worked with R1 at his previous facility, and he utilized a transfer pole there. Consultant GG stated that the facility had access to transfer poles and if a resident wanted a transfer pole. Consultant GG said transfer poles could be ordered and put up for the resident to aid in maintaining independence. Consultant GG further stated that R1 was very vocal and would tell staff what he wanted, so Consultant GG did not understand why she had not heard that R1 wanted a transfer pole.

On 02/22/24 at 12:33 PM, Consultant HH stated that R1 worked on becoming independent with transfers and used the bed cane to aid his transfers in and out of bed. Consultant HH stated that R1 originally asked about a transfer pole, but after he worked with therapy on transfers in and out of bed, he did not mention it again. Consultant HH revealed she never asked if R1 wanted the transfer pole after he mentioned it at the first assessment. Consultant HH stated that when the transfer pole was brought in for R1 from an outside service, it was put up by maintenance. Consultant HH said she evaluated if the transfer pole was safe to use for R1. Consultant HH stated that the transfer pole bent in the middle due to the connection and she felt that particular transfer pole was unsafe for R1 to use.

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On 02/22/24 at 12:40 PM, R1 sat in his wheelchair and appeared clean. R1 stated he talked to "everyone" about his desire for a transfer pole, but he never received one from the facility. R1 stated he spoke with Administrative Staff A about the transfer pole. R1 said Administrative Staff A told him that the facility could not provide a transfer pole. R1 stated that when the outside service brought a transfer pole to the building for R1, he had to wait for maintenance to put the pole up and then for someone from therapy to evaluate if the pole was safe to use. R1 revealed that Consultant HH came and assessed the transfer pole, determined the pole was unsafe, and removed the pole. R1 became visibly upset as he talked about the transfer pole being removed from his room. R1 revealed that no one asked him if he wanted another transfer pole put up. R1 stated that he used the bed cane to transfer out of bed but pulling on that to get up caused his bed to slide when he transferred.

On 02/22/24 at 01:15 PM Administrative Staff A stated R1 had a bed cane as an aid to transfers in and out of bed. Administrative Staff A stated she never heard that R1 wanted a transfer pole and had no idea where the idea came from. Administrative Staff A stated R1 had not requested to have a transfer pole. Administrative Staff A revealed she had not asked R1 if he wanted a transfer pole, even after the outside service had provided a transfer pole that was deemed unsafe for use.

On 02/22/24 at 01:20 PM, Consultant GG stated she reviewed her communication with Consultant HH and stated Consultant HH texted when R1

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arrived asking about the process to request a transfer pole for R1. Consultant GG stated she must have missed that communication. Consultant GG stated she had not asked R1 if he wanted a transfer pole.

On 02/22/24 at 01:22 PM Administrative Nurse D stated she had not asked R1 if he wanted a transfer pole.

The facility's policy "Resident Rights" reviewed 09/25/23 documented the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has the right to receive the services and/or items included in the plan of care.

the facility failed to accommodate R1's need and preference for a transfer pole to assist with bed transfers. This placed R1 at risk of decreased mobility and impaired autonomy.