

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/20/2024
NAME OF PROVIDER OR SUPPLIER CEDAR LAKE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 15325 S LONE ELM RD OLATHE, KS 66061		
(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 an abbreviated survey with review of facility reports #185777 and #185734 at the above assisted living conducted on 02/19/24 and 02/20/24.	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: 26-41-101(f)(1)(B) The facility reported a census of 52 total residents with 16 in the memory care unit. Two memory care residents were included in the sample for abbreviated review. Based on interview and record review the administrator failed to protect Resident (R) 2 from neglect by ensuring certified staff assisted R2 up off the floor after a witnessed, non-injury fall. Findings included: - Record review for R2 revealed an admission date of 03/29/22 with a diagnosis of dementia.	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 The 03/22/23 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with bathing and dressing, was independent with transfers and walking/mobility and was marked for falls. The 03/22/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide R2 assistance with bathing and dressing; encouragement to wear proper footwear and provided a motion sensor to prevent injury from falls. The facility's investigation report provided during the survey documented review of video footage from 02/02/24 at approximately 02:50 AM revealed R2 approached a sleeping resident in the common area. CMA C redirected R2 away from the sleeping resident. R2 fell to the ground and CMA C returned to sitting in a chair. R2 crawled approximately six feet toward a chair and used it to pick herself up off the floor. CMA C failed to provide assistance or stabilization of the chair for R2. Review of the staff training transcript for CMA C revealed she completed "Abuse and Neglect of the Vulnerable Adult" online training on 07/20/22 and 12/11/23. On 02/19/24 at 03:59 PM Administrative Staff A confirmed the video footage revealed CMA C did not assist R2 up from the floor. The administrator failed to protect R2 from neglect by ensuring certified staff assisted R2 up off the floor after a witnessed, non-injury fall.	S3026		