

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/07/2024
NAME OF PROVIDER OR SUPPLIER TRUSTWELL LIVING OF MISSION SPRINGS II		STREET ADDRESS, CITY, STATE, ZIP CODE 5350 WEST 61ST PLACE MISSION, KS 66205		
(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 an abbreviated survey for complaints #185388 of the above named facility conducted on 05/17/24.	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 39 residents with one resident included in the sample. Based on interview and record review the operator failed to	S 135		

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

TITLE

(X6) DATE

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S 135	Continued From page 1 ensure licensed staff notified the legal representative or designated family members when Resident (R) 1 was administered the wrong medications. Findings included: - Record review for R1 revealed an admission date of 09/16/22 with a diagnosis of dementia. The 01/09/23 "Functional Capacity Screen" (FCS) identified R1 was unable to manage medications had short term memory, memory/recall, and decision-making difficulties; and was marked for impaired decision-making. The 06/21/23 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff provided management of medications; occasional reminders and redirection for cognitive difficulties; and reminders and encouragement to attend activities for impaired decision-making. The 10/13/23 at 06:04 PM "Resident Note" by Licensed Nurse C documented a Certified Medication Aide (CMA) reported she gave R1 another resident's medications by mistake. Advanced Registered Nurse Practitioner (ARNP) D and the corporate nurse were notified. ARNP stated R1 should be okay, but she would probably be sedated. The 10/13/23 at 06:52 PM "Resident Note" by Licensed Nurse C documented a CMA reported that R1 was not feeling well. Nurse's assessment revealed R1 had weakness and congestion and tested positive for COVID. ARNP D, the corporate nurse and R1's unidentified family member were notified. New orders to treat signs and symptoms	S 135			

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S 135	Continued From page 2 of COVID were received. The 10/14/23 at 09:05 AM by Licensed Nurse C documented R1 was breathing but unresponsive. She was sent to the hospital. The 10/14/23 handwritten "Progress Note" by Licensed Nurse B documented R1 was unresponsive with vital signs within normal limits. R1 had received another resident's medications by accident. R1's provider was notified with no new orders. R1's unidentified family member was notified that R1 was transferred to the hospital. Review of "Resident Notes" from 10/13/23 and 10/14/23 lacked evidence of documentation R1's designated family member was notified R1 received another resident's medication. The 09/01/23 "Significant Change of Condition" policy documented a change of condition is identified as a condition of an illness or incident and would be reported to the Health Service Director (HSD). The HSD would notify the physician and responsible party and document notifications. The operator failed to ensure licensed staff notified the legal representative or designated family members when R1 was administered the wrong medications.	S 135			
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	S3101			

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S3101	Continued From page 3 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 39 residents with one resident included in the sample. Based on interview and record review the operator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 1. Findings included: - Record review for R1 revealed an admission date of 09/16/22 with a diagnosis of dementia. The 01/09/23 "Functional Capacity Screen" (FCS) identified R1 was unable to manage medications had short term memory, memory/recall, and decision-making difficulties; and was marked for impaired decision-making. The 06/21/23 "Negotiated Service Agreement" NSA identified facility staff provided management of medications; occasional reminders and redirection for cognitive difficulties; and reminders and encouragement to attend activities for impaired decision-making. The 06/21/23 "NSA" was signed by the resident and the operator but lacked a nurse signature. On 05/07/24 at 03:07 PM Administrative Staff A confirmed R1's "NSA" was not signed by the nurse involved.	S3101		

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S3101	Continued From page 4 The facility's 12/01/23 "Care Plan" policy provided by the facility failed to address who was required to sign the agreement. The operator failed to ensure that each individual involved in the development of the "NSA" signed the agreement for R1.	S3101			