

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 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 6921 W 81ST STREET OVERLAND PARK, KS 66204		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint #189130, #189030, #188568, and #186318 at the above named assisted living conducted on 07/22/24 and 07/23/24.	S 000		
S3026 SS=J	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: KAR 26-41-101(f)(1)(B) The facility reported a census of 61 residents with six residents included in the sample and two closed record reviews. Based on observation, interview, and record review the administrator failed to protect cognitively impaired Residents (R)3 and R4 from neglect when they exited the building through an unsecured door and an unlocked courtyard gate without staff knowledge. An unidentified patron from a nearby business informed the facility staff she saw R3 and R4 at the corner of a busy intersection. This placed R3 and R4 in Immediate Jeopardy. Findings included:	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 - Record review for R3 revealed an admission date of 08/30/22 with diagnoses of: Alzheimer's disease and dementia. The 03/22/24 "Functional Capacity Screen" (FCS) identified R3 required physical assistance with transfers; supervision with walking/mobility; had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties; and was marked for impaired decision-making. The 03/22/24 combined "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HSP) identified facility staff would provide physical assistance of one staff for transfers; supervision for walking/mobility; would encourage resident to participate in activities of daily living (ADL's) and allow her ample time for cognitive difficulties; staff would ask yes/no questions and allow time for R3 to respond and she had a Durable Power of Attorney (DPOA) for impaired decision-making. The 06/13/24 at 07:57 AM "Progress Note" documented the nurse notified R3's DPOA she left the building unescorted and returned without difficulties and no signs of injury. - Record review for R4 revealed an admission date of 06/14/23 with diagnoses of chest pain and hypertension. The 06/20/24 "FCS" identified R4 was independent with transfers and walking/mobility with a walker or wheelchair; had short-term and long-term memory, memory/recall, and impaired decision-making cognitive difficulties; and was marked for impaired decision-making and wandering. The 06/29/24 "NSA/HSP" identified facility staff	S3026		

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S3026	Continued From page 2 would ask yes/no questions and allow R4 enough time to respond for cognitive difficulties; staff provided assistance with day-to-day decisions and his DPOA was responsible for major decisions; and staff provided monitoring, redirection, and encouragement to join activities for wandering. The 06/13/24 at 08:12 AM "Progress Note" documented the nurse notified R4's DPOA he left the building unescorted and returned without difficulties with no signs of injury. The 06/14/24 "Intake Information" emailed to the department reported on 06/13/24 at approximately 06:55 AM R3 and R4 were outside the building without supervision. Staff found the alarm on the door they exited from was not working. The undated facility's "Investigation" provided during the survey reported the following: On 06/13/24 at 07:10 AM an unidentified patron from a nearby business reported R3 and R4 were standing at the corner of a busy intersection one block from the facility. Administrative Nurse B assisted R3 and R4 back to the facility. R4 was able to show Administrative Nurse B they exited the building through the door on the 100 hall. The light on the 100-hall door indicated the alarm was armed but when staff tested the door, the alarm failed to activate. An assigned staff member guarded the door until maintenance staff arrived to check the door. Facility staff reviewed camera footage in the front lobby area. At 06:02 AM R3 pushed R4 in the front lobby area in a wheelchair. They headed down the 100 hall toward R4's room and	S3026		

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S3026	Continued From page 3 disappeared out of camera range. Administrative Nurse B reported in the facility's "Investigation" to the department actions taken to keep R3 and R4 safe from elopement included staff provided visual observation of R3 and R4's location in the facility every hour for 12 hours and then every 2 hours for 12 hours. The 06/13/24 at 07:38 AM "Witness Statement" included in the facility's "Investigation" by Certified Medication Aide (CMA) F reported R4 exhibited restlessness and exit-seeking all night on 06/12/24 into the morning of 06/13/24 by setting off door alarms throughout the night and into the morning. She last saw him at 05:50 AM when he refused his medication. He and R3 were near each other. Staff previously redirected them during attempts to elope, monitored doors, and listened for alarms. The 06/13/24 "Witness Statement" included in the facility's "Investigation" by facility staff member (signature was unreadable) reported she observed R3 and R4 walked inside the facility all night trying to exit. She and another staff kept watch over them and monitored the doors. She last saw R4 sitting in a wheelchair with R3 standing next to him at 06:30 AM. The 06/13/24 "Witness Statement" included in the facility's "Investigation" by Certified Nurse Aide (CNA) G reported she redirected R3 and R4 away from the 500-hall exit door at approximately 04:00 AM when they attempted to get out of the building. The 06/13/24 "120 Minute Check List" documented R3 was in the following locations within the facility at the following times:	S3026		

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S3026	Continued From page 4 11:00 PM - Bed 01:00 AM - Bed 03:00 AM - Bed 05:00 AM - Bed and bathroom 07:00 AM - Awake and in bed R3's record lacked evidence of documentation facility staff provided hourly visual checks of her location in the facility from time of re-entry to facility after she eloped on 06/13/24 until 11:00 PM the same evening. The 06/13/24 "60 Minute Check List" documented staff checked on R4 at the following times: 08:00 AM, 09:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 01:00 PM, 02:00 PM, and 03:00 PM. The 06/13/24 "120 Minute Check List" for night shift documented R4 was in the following locations within the facility at the following times: 11:00 PM - In room asleep 01:00 AM - In room asleep 03:00 AM - In room asleep 05:00 AM - In room asleep 07:00 AM - In room asleep R4's record lacked evidence of documentation facility staff provided hourly visual checks of his location in facility from 03:00 PM on 06/13/24 until 11:00 PM The 06/13/24 at 09:55 AM "Work Order #646" by Maintenance Staff H documented the 100-hall exit door did not relatch after the alarm sounded. It appeared something spilled on the door push bar. Maintenance Staff H lubricated the mechanism and tested the door multiple times to ensure the alarm worked as it should.	S3026		

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S3026	Continued From page 5 Review of the facility's "Logbook Documentation Task Name: Test Operation of Doors and Locks" from 01/02/24 to 06/13/24 (day of elopement) revealed maintenance staff checked the doors and locks and found them working as designed monthly on 01/02/24, 02/01/24, 03/04/24, 04/04/24, 05/07/24, and later on 06/13/24 (post elopement door repair). Facility records lacked documentation doors and alarms were checked from 05/07/24 to 06/13/24, which was 37 days. The 05/02/24 "Missing Resident Drill" documented 22 facility staff participated in the elopement drill. The 05/30/24 "Code Silver Drill" documented 12 facility staff participated in the elopement drill. Review of the facility's "Resident Roster" provided during the survey revealed 14 residents were marked for wandering. Observation on 07/23/24 at approximately 09:30 AM revealed a probable route R3 and R4 took when they exited the facility. It was approximately eight steps from R4's room door to the exit door on the 100 hall. Outside the door was a courtyard secured with a tall fence and locked gate. It was approximately six steps from the exit door to the courtyard gate. Administrative Nurse B unlocked the gate. Administrative Nurse B and state surveyor walked from the gate, across a residential street with a speed limit of 25 miles per hour (mph), up the sidewalk to the entrance to a parking garage, through the parking garage, across a parking lot to a sidewalk next to a busy 4 lane street with a speed limit of 35 mph and continued up the sidewalk to the street corner where R3 and R4 were found. According to Google Maps the distance from the courtyard	S3026		

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S3026	Continued From page 6 gate to the street corner was approximately 800 feet. The weather on 06/13/24 according to Wunderground.com was 73 degrees Fahrenheit with a wind speed of 12 mph at 06:53 AM. On 07/23/24 at 09:46 AM Maintenance Staff H stated facility staff had not reported to him the 100-hall door had issues. On 07/23/24 at 09:52 AM Administrative Staff A confirmed R3 and R4 eloped on 06/13/24. Administrative staff provided training during an all-staff meeting on 06/06/24 how to re-set the door alarms after residents pushed on the door and activated the alarm. Administrative Staff A demonstrated the procedure on a door to three new staff. He stated whenever he heard there was confusion from staff regarding the procedure, he re-educated them but did not document the training every time. Facility staff had not reported to him the 100-hall door had issues. On 07/23/24 at 09:57 AM during a phone interview CMA F stated staff were not aware the 100-hall door had issues. Another door, the 500-hall door, had previously had issues which maintenance fixed, but staff continued to keep a close eye on it. On 07/23/24 at approximately 11:43 AM Administrative Staff A stated the 100-hall door should have alarmed when R3 and R4 exited the building. On 07/23/24 at approximately 11:43 AM Administrative Nurse B stated when he arrived in the facility the morning of 06/13/24 the 100-hall door did not alarm.	S3026		

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S3026	Continued From page 7 On 07/23/24 at 12:52 PM Administrative Nurse B confirmed the most recent date before the elopement maintenance staff checked door alarms was 05/07/24. A company providing maintenance oversight visited the facility on 04/03/24 and told facility maintenance staff to keep the courtyard gate unlocked. Facility staff followed the directive and the courtyard gate remained unlocked from 04/03/24 to the time of the elopement on 06/13/24 when staff locked the gate again. On 07/24/24 at 03:33 PM a "Elopement" policy was requested by email which the facility failed to provide. The administrator failed to protect cognitively impaired R3 and R4 from neglect when they exited the building through an unsecured door and through an unlocked courtyard gate, without staff knowledge. An unidentified patron from a nearby business informed facility staff she saw R3 and R4 at the corner of a busy intersection. Jeopardy was removed on 07/23/24 when the following actions were documented by the facility in the "Abatement of Elopement on 06/13/24" plan and accepted by the department at 03:05 PM. 1) Facility staff secured R3 and R4 on 06/13/24 and checked them for any problems. 2) On 06/13/24 at 07:30 AM a guard watched the 100-hall exit door because it was inoperative. 3) On 06/13/24 at 09:30 AM the 100-hall exit door was repaired and checked for operation. The courtyard gate was also secured at this time per direction of Administrative Staff A. 4) On 06/13/24 at 09:30 AM hourly checks were	S3026		

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S3026	Continued From page 8 initiated to check the 100-hall exit door for 24 hours. 5) Training to all staff regarding securing the doors and ensuring alarms were armed was completed on 06/13/24 and 06/14/24. 6) The charge nurse or CMA would check emergency doors every shift and document on a log maintained in the nurse's station. All problems would be reported to Administrative Nurse A or Administrative Nurse B immediately.	S3026		
S3211 SS=F	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 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: KAR 26-41-205 (g)(3) The facility reported a census of 63 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of	S3211		

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S3211	Continued From page 9 ten over-the-counter (OTC) medications in the assisted living. Findings included: - Observation on 07/22/24 at 12:50 PM revealed Certified Medication Aide (CMA) J unlocked and opened medication cart #1. The following OTC medications were not labeled with residents' full names: Two bottles of Areds, 120 softgels One bottle of aspirin 81 milligrams (mg), 120 tablets One bottle vitamin B-12 500 mg, 100 tablets One bottle of Red Yeast Rice 600 mg, 120 capsules One bottle of vitamin D-3 2000 international units (iu) One bottle of calcium 500 mg, 60 gummies One bottle of Centrum Men's Daily 275 tablets On 07/22/24 at approximately 12:50 PM Administrative Nurse B confirmed seven OTC medications on medication cart #1 were not labeled with residents' full names. Observation on 07/22/24 at 01:00 PM revealed CMA K unlocked and medication cart #2. The following OTC medications were not labeled with residents' full names: One bottle of atorvastatin One bottle of famotidine 20 mg, 100 tablets One bottle of vitamin B-12 500 mcg, 200 tablets On 07/22/24 at approximately at 01:00 PM Administrative Nurse B confirmed three OTC medications on medication cart #1 were not labeled with residents' full names.	S3211		

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S3211	Continued From page 10 On 07/24/24 at 03:33 PM a "Medication Storage" policy was requested by email which the facility failed to provide. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eight OTC medications.	S3211		
S3261 SS=D	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: KAR 26-41-105(f)(11) The facility reported a census of 63 residents with six residents and two closed record reviews included in the sample. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R)5 had an injury to her forehead that required sutures. Findings included: - Record review for R5 revealed an admission date of 08/19/21 with diagnoses of dementia and	S3261		

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S3261	Continued From page 11 psychosis. The 09/28/23 "Functional Capacity Screen" (FCS) identified R5 required physical assistance with bathing, dressing, toileting; was unable to perform management of medications and treatments; was incontinent of bladder; had short-term and long-term memory, memory/recall, and decision-making difficulties, and was marked for impaired decision-making. The 11/19/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide physical assistance with bathing, dressing, and toileting every two to three hours; management of medications and performance of treatments per Primary Care Provider's (PCP) orders; reminders and assistance to activities for cognitive difficulties; and assistance with day-to-day decisions while her Durable Power of Attorney (DPOA) made financial decisions for impaired decision-making. The 02/06/24 at 09:44 PM "Progress Note" documented "according to the communication book" R5 had a skin tear between 11:00 PM on 02/05/24 and 07:00 AM on 02/06/24. The writer cleaned the skin tear and applied "strips," antibiotic ointment and a non-stick pad. The note failed to document skin tear size (length, width, and depth), drainage, and any signs of infection. The 02/14/24 at 10:27 AM "Progress Note" documented "this writer saw the note left by night shift" that R5 had a skin tear to her right wrist was cleaned and dressed. "This writer did a new dressing." The 02/19/24 at 03:59 PM Late Entry "Progress Note" documented R5 was seen by the nurse	S3261		

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S3261	Continued From page 12 practitioner and sutures were removed from her left forehead. Review of R5's record from 02/06/24 to 02/29/24 revealed lack of evidence licensed staff documented the incident including date and time, actions taken and results of the actions that cause R5 to have sutures in her left forehead. On 07/23/24 at approximately 04:12 PM Administrative Nurse B stated he expected licensed staff to document all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action for all residents. He confirmed R5's record lacked evidence licensed staff documented when R5 suffered an injury that required sutures to her left forehead. On 07/24/24 at 03:33 PM a "Nursing Documentation" policy was requested by email which the facility failed to provide. The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when R5 had an injury to her forehead that required sutures.	S3261		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all	S3298		

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S3298	Continued From page 13 applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident 's family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 63 residents. The facility had a main kitchen where food was stored, prepared, and served. Based on interview and record review, the administrator failed to ensure dietary staff served food at the proper temperature. Findings included: - Observation on 07/22/24 at 12:37 PM of the kitchen revealed a notebook which contained food temperature logs for the month of July 2024. Review of the food temperature log from 07/01/24 to 07/22/24 revealed dietary staff failed to log temperatures for all three meals on 12 out of 21 days on the following dates: 07/01/24, 07/02/24, 07/05/24, 07/06/24, 07/07/24, 07/10/24, 07/11/24, 07/15/24, 07/16/24, 07/19/24, 07/20/24, 07/21/24.	S3298		

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NAME OF PROVIDER OR SUPPLIER MORNINGSIDE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 6921 W 81ST STREET OVERLAND PARK, KS 66204		
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S3298	Continued From page 14 On 07/22/24 at approximately 12:37 PM Administrative Nurse B confirmed dietary staff failed to log temperatures for all three meals on 12 out of 21 days The Kansas Department of Agriculture's "Focus on Food Safety" booklet documented "minimum hot holding temperature is 135 degrees Fahrenheit (F)." and "maximum cold holding temperature is 41 degrees F. On 07/24/24 at 03:33 PM a "Food Temperature" policy was requested by email which the facility failed to provide. The administrator failed to ensure dietary staff served food at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 63 residents. The facility had a main kitchen where food was stored, prepared, and served. Based on observation and interview the administrator failed to ensure food items were stored under safe	S3299		

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S3299	Continued From page 15 conditions. Findings included: - Observation on 07/22/24 at 12:37 PM of the kitchen revealed one walk-in refrigerator and four upright freezers with temperature logs posted on the front of each. Review of the four "Daily Freezer/Refrigerator Temperature Logs" from 07/01/24 to 07/22/24 revealed dietary staff failed to log temperatures for 12 out of 21 total opportunities on the following dates: 07/01/24, 07/02/24, 07/05/24, 07/06/24, 07/07/24, 07/10/24, 07/11/24, 07/15/24, 07/16/24, 07/19/24, 07/20/24, 07/21/24. On 07/22/24 at approximately 12:37 PM Dietary Staff E confirmed dietary staff failed to log refrigerator and freezer temperatures daily. The August 2017 Kansas Department of Agriculture's "Focus on Food Safety" booklet documented food items could be held up to seven days if refrigeration was adequate at 41 degrees Fahrenheit or less. On 07/24/24 at 03:33 PM a "Food Storage" policy was requested by email which the facility failed to provide. The administrator failed to ensure foods were stored under safe conditions.	S3299		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a	S3310		

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S3310	Continued From page 16 communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 63 residents. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two staff. Findings included: - Review of Administrative Nurse C's employee record revealed a hire date of 06/17/24 and lacked evidence the facility completed TB testing within seven days of hire. On 07/23/24 at 12:12 PM Administrative Staff I confirmed Administrative Nurse C's record lacked evidence the facility completed TB testing within seven days of hire.	S3310		

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S3310	Continued From page 17 - Review of Certified Nurse Aide (CNA) D's employee record revealed a hire date of 05/28/24 and lacked evidence the facility completed TB testing within seven days of hire. On 07/23/24 at 12:12 PM Administrative Staff I confirmed CNA D's record lacked evidence the facility completed TB testing within seven days of hire. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission. On 07/24/24 at 03:33 PM a "TB" policy was requested by email which the facility failed to provide. The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		
S3420 SS=F	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the	S3420		

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S3420	Continued From page 18 temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256 (c)(2)(B) The facility reported a census of 63 residents. Based on observation and interview the administrator failed to ensure maintenance staff maintained the water temperature in a public	S3420		

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S3420	Continued From page 19 restroom sink accessible by residents between 98 degrees Fahrenheit (F) and 120 degrees F. Findings included: - Observation on 07/22/23 at 01:25 PM revealed a public restroom in the hallway which was accessible to the residents. The water temperature in the sink was 126.8 degrees F per facility's thermometer. On 07/22/23 at approximately 01:25 PM Administrative Staff A and Maintenance Staff H confirmed the water temperature in the sink was 126.8 degrees F. On 07/24/24 at 03:33 PM a "Water Temperature" policy was requested by email which the facility failed to provide. The administrator failed to ensure maintenance staff maintained the water temperature in a public restroom sink accessible by residents between 98 degrees F and 120 degrees F.	S3420		