

Kansas Department on Aging

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046059</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/30/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15325 S LONE ELM RD<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S 000                                                         | INITIAL COMMENTS<br><br>The following citations represent the findings of a<br>resurvey with a complaint 188813, 188995,<br>190314, 190488, and 190578 at the above<br>named Assisted Living conducted on 01/28/25,<br>01/29/25, and 01/30/25.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | S 000                                                                                    |                                                                                                                          |                                                        |
| S3026<br>SS=J                                                 | 26-41-101 (f) (1) Staff Treatment of Residents<br>ANE<br><br>(f)The administrator or operator shall ensure that<br>all of the following requirements are met:<br>(1) No resident shall be subjected to any of the<br>following:<br>(A) Verbal, mental, sexual, or physical abuse,<br>including corporal punishment and involuntary<br>seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced<br>by:<br>KAR 26-41-101(f)(1)(C)<br><br>The facility reported a census of 51 residents,<br>with three residents included in the sample and<br>two closed record reviews. Based on<br>observation, interview and record review, the<br>administrator failed to protect resident (R)104<br>from exploitation when "Certified Medication<br>Aide" (CMA) C took a photo of R104's skin tears<br>and posted to a private group chat through a<br>social media provider. This placed R104 in<br>Immediate Jeopardy for exploitation.<br><br>Findings included: | S3026                                                                                    |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE

Kansas Department on Aging

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| S3026                                                         | <p>Continued From page 1</p> <p>- Record review for R104 revealed an admission date of 11/01/20 with a diagnosis of epilepsy.</p> <p>The 08/26/23 "Functional Capacity Screen" (FCS) identified R104 was unable to perform management of medications and treatments.</p> <p>The 08/26/23 "Negotiated Service Agreement" (NSA) identified facility staff provided R104 assistance with management of medications but did not address management of treatments.</p> <p>In an email dated 09/13/24, a summary of an interview with CMA C documented that CMA C verified she posted two pictures of R104's skin tears on a social media chat group consisting of about 30 individuals. CMA C stated she did not know why she posted the pictures and that she had no reason to post those pictures. CMA C stated she included wording on the pictures to cover up what was in the background of the pictures. Administrative Nurse D stated this was CMA C's second privacy violation and at that time she was reeducated on privacy.</p> <p>The "Facility Investigation Report" received by the State Agency on 09/16/24 documented Administrative Nurse D sent Administrative Staff A an image of two skin tears R104 developed after he experienced a fall. It was reported the pictures of R104's injuries were posted to a private group chat through social media accessible by approximately 30 persons. This social media post included words and other pictures added over the pictures. CMA C had first sent the unaltered images to the nurse on call for</p> | S3026                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3026                                                         | <p>Continued From page 2</p> <p>guidance on bandaging. CMA C was instructed to delete the images from her phone. CMA C decided instead to post these pictures to a social media group. During an interview with Administrative Staff A, CMA C admitted to posting the images and stated she was not sure why she did it. CMA C was terminated for breach of facility policies. A review of staff training concerning the "Health Insurance Portability and Accountability Act (HIPAA) Privacy" was current for all staff.</p> <p>Interview on 01/30/25 at 10:17 AM with CMA E stated staff were allowed to take pictures of residents only if there was a consent form. CMA E stated no pictures of wounds and no posting on social media was allowed. CMA E stated she had completed education regarding social media at least annually.</p> <p>Interview on 01/30/25 at 10:25 AM with CNA F stated prior to the incident in question, it was her understanding that no staff were to take pictures and staff were not to post on social media due to HIPPA concerns. CNA F stated after the incident all staff were re-educated on policies covering photos and social media.</p> <p>Interview on 01/30/25 at 10:09 AM with "Licensed Nurse" (LPN) G stated education had been provided to staff concerning photos and social media and it was not common practice to have staff take photos of wounds.</p> <p>Interview on 01/29/25 at 02:52 PM with Administrative Staff A stated all newly hired staff had to review policies on photos and social media prior to being onboarded. Administrative</p> | S3026                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3026                                                         | <p>Continued From page 3</p> <p>Staff A stated there was staff training on "HIPAA Security" after the incident, and stated it was his expectation of staff to never take photos of residents and to never post anything on social media.</p> <p>The 05/18/22 facility's "Social Media - Enterprise" policy documented "Information should never contain information that identifies or potentially identifies a patient's identity or health condition in any way. This includes descriptions of injuries, conditions, or behaviors as well as photos, videos, or any other images of patients, even if not obviously identifiable. . . "</p> <p>The administrator failed to protect R104 from exploitation when CMA C took photos of R104's skin tears and posted them to a private group chat through a social media provider.</p> <p>Jeopardy was removed on 01/30/25 when the following actions were documented by the facility in the "Abatement Plan - Resident Privacy Violation" and accepted by the department at 10:52 AM.</p> <p>1. The facility has worked with all involved parties to ascertain the following facts:</p> <p>a. Photo of an injury sustained by unidentifiable resident was taken by staff member and sent to on-call LPN. She was directed to delete the photo and before deleting it, she posted to a private group on a social media site which removed the image after being viewed by the recipient.</p> <p>b. An unidentified source sent a screenshot of the shared image to Administrative Nurse D.</p> | S3026                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3026                                                         | <p>Continued From page 4</p> <p>c. Administrative Nurse D reported this to the Administrator, who turned in a self-report to KDADS on 09/19/2024, with CP# being provided with request for full investigation.</p> <p>d. All digital copies that were sent via text were deleted by parties, and not re-shared outside of KDADS and facility's corporate staff.</p> <p>e. In the interview with offending staff member, she accepted responsibility for her actions, stating that we were very clear about expectations and knew it was wrong immediately after she did it.</p> <p>2. The facility has already provided the following as corrective action and means of prevention:</p> <p>a. Staff member had already been on a FINAL Warning for violation of our HIPAA &amp; Privacy Guidelines and was therefore terminated on 09/18/24.</p> <p>b. HIPAA &amp; Privacy is provided upon hire and renewed annually by all staff.</p> <p>c. The HIPAA training was manually assigned to any person who had not yet completed their annual training/re-training for 2024 after incident.</p> <p>3. The facility will provide the following as corrective action and means of prevention:</p> <p>a. Provide immediate (01/31/25) training resource document on HIPAA &amp; Privacy for nursing staff to read and sign off on prior to their next shift.</p> <p>b. Provide further instruction and reminder on our privacy policies, and restriction of photography at next nursing staff meetings scheduled on 02/04/2025</p> <p>c. Any staff member who has not completed</p> | S3026                                                                                    |                                                                                                                          |                                                        |

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| S3026                                                         | Continued From page 5<br><br>their annual HIPAA training modules will be<br>manually assigned to be<br>renewed/completed by 03/31/25.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | S3026                                                                                    |                                                                                                                          |                                                        |
| S3085<br>SS=E                                                 | 26-41-202 (a) Negotiated Service Agreement<br><br>(a) The administrator or operator of each<br>assisted living facility or residential health care<br>facility shall ensure the development of a written<br>negotiated service agreement for each resident,<br>based on the resident ' s functional capacity<br>screening, service needs, and preferences, in<br>collaboration with the resident or the resident ' s<br>legal representative, the case manager, and, if<br>agreed to by the resident or the resident ' s legal<br>representative, the resident ' s family. The<br>negotiated service agreement shall provide the<br>following information:<br>(1) A description of the services the resident will<br>receive;<br>(2) identification of the provider of each service;<br>and<br>(3) identification of each party responsible for<br>payment if outside resources provide a service.<br><br>This REQUIREMENT is not met as evidenced<br>by:<br>KAR 26-41-202(a)(1)<br><br>The facility reported a census of 51 residents<br>with three residents included in the sample and<br>two abbreviated record reviews completed.<br>Based on interview, and record review the<br>administrator failed to ensure the "Negotiated<br>Service Agreement" (NSA) was fully developed<br>based on the resident's "Functional Capacity | S3085                                                                                    |                                                                                                                          |                                                        |

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| S3085                                                         | <p>Continued From page 6</p> <p>Screen" (FCS), service needs, and preferences for resident (R)102, and R103.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R102's medical record revealed he moved into the facility on 04/24/24 with a diagnosis of Frontotemporal Neurocognitive Disorder.</li> </ul> <p>The 04/22/24 FCS identified R102 was unable to manage treatments.</p> <p>The 06/05/24 NSA did not address management of treatments.</p> <p>Review of R102's medical records revealed documentation of wound treatments completed by the facility nursing staff and outside wound care providers.</p> <p>On 01/29/25 at 01:11 PM Administrative Nurse D acknowledged R102's NSA did not address services provided by staff and outside providers concerning medical treatments to include wound care.</p> <p>The administrator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences.</p> <ul style="list-style-type: none"> <li>- R103's medical record revealed she moved into the facility on 03/19/24.</li> </ul> <p>The 03/18/24 FCS identified R103 was unable to manage treatments and had impaired vision.</p> | S3085                                                                                    |                                                                                                                          |                                                        |

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| S3085                                                         | Continued From page 7<br><br>The 03/15/24 NSA did not address what services staff provided R103 concerning management of treatments and impaired vision.<br><br>On 01/29/25 at 04:00 PM Administrative Nurse K stated the NSA did not address impaired vision or medical treatments.<br><br>The administrator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.                                                                                                                                                                                                                                                                                                                             | S3085                                                                                    |                                                                                                                          |                                                        |
| S3092<br>SS=E                                                 | 26-41-202 (d) Negotiated Service Agreement Revisions<br><br>(d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days;<br>(2) following any significant change in condition, as defined in K.A.R. 26-39-100;<br>(3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and<br>(4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family.<br><br>This REQUIREMENT is not met as evidenced by:<br>3092<br>26-41-202(d)(1)(4) | S3092                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15325 S LONE ELM RD<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |
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| S3092                                                         | <p>Continued From page 8</p> <p>The facility reported a census of 51 residents. The sample included three residents and two focused record reviews. Based on interview, and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for resident (R)102 was revised when an outside provider was added for wound care services and failed to ensure R104's NSA was reviewed and revised annually and again when he was placed on hospice.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R102's medical record revealed he moved into the facility on 04/24/24 with a diagnosis of Frontotemporal Neurocognitive Disorder.</li> </ul> <p>The 04/22/24 "Functional Capacity Screen" (FCS) documented R102 was independent with transfers and mobility, was occasionally incontinent of bladder and was unable to manage treatments.</p> <p>The 06/05/24 NSA did not address management of treatments and staff assisted with incontinent products. There was no mention of services provided concerning the treatment of pressure wounds. The NSA was not revised to include wound care services provided by an outside provider.</p> <p>On 01/29/25 at 01:11 PM Administrative Nurse D stated she did not complete an addendum to R102's NSA when he started receiving services for wound care from an outside provider.</p> <p>The administrator failed to ensure R102's NSA</p> | S3092                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3092                                                         | Continued From page 9<br><br>was revised when he started services with an outside provider for wound care.<br><br>- R104's medical record revealed he moved into the facility on 11/01/20 with a diagnosis of epilepsy.<br><br>The most recent NSA completed for R104 was dated 08/26/23.<br><br>Review of R104's medical records revealed an order dated 05/31/24 for him to be admitted to hospice.<br><br>On 01/30/25 at 10:00 AM Administrative Nurse K stated she was on leave when R104's annual review and revision of his NSA should have been completed and no other nurse followed through with this. Administrative Nurse D confirmed R104 was admitted to hospice, but no addendum was completed for this at that time<br><br>The administrator failed to ensure R104's NSA was updated at least once every 365 days and when he experienced a significant change in condition requiring admission to hospice services. | S3092                                                                                    |                                                                                                                          |                                                        |
| S3105<br>SS=D                                                 | 26-41-202 (j) Negotiated Service Agreement Outside Resource<br><br>(j) If a resident's negotiated service agreement includes the use of outside resources, the designated facility staff shall perform the following:<br>(1) Provide the resident, the resident's legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | S3105                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3105                                                         | <p>Continued From page 10</p> <p>representative, the resident ' s family, with a list of providers available to provide needed services;</p> <p>(2) assist the resident, if requested, in contacting outside resources for services; and</p> <p>(3) monitor the services provided by outside resources and act as an advocate for the resident if services do not meet professional standards of practice</p> <p>This REQUIREMENT is not met as evidenced by:<br/>3105<br/>KAR 26-41-202(j)(3)</p> <p>The facility reported a census of 51 residents. The sample included three residents and two abbreviated record reviews. Based on interview and record review the administrator failed to ensure designated staff monitored services provided by outside resources for resident (R)102 when nursing staff failed to ensure hospice and wound care providers documented assessments, treatments and outcomes concerning R102's pressure wounds.</p> <p>Findings included:</p> <p>- R102's medical record revealed he moved into the facility on 04/24/24 with a diagnosis of Frontotemporal Neurocognitive Disorder.</p> <p>The 04/22/24 "Functional Capacity Screen" (FCS) documented R102 was independent with transfers and mobility, was occasionally incontinent of bladder and was unable to</p> | S3105                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3105                                                         | <p>Continued From page 11</p> <p>manage treatments.</p> <p>The 06/05/24 "Negotiated Service Agreement" (NSA) did not address management of treatments and staff assisted with incontinent products. There was no mention of services provided concerning the treatment of pressure wounds.</p> <p>01/07/25 "Hospice Nursing Notes" documented the start of a wound on R102's backside, middle of two buttocks.</p> <p>01/14/25 "Hospice Nursing Notes" documented a physician was to assess R102's wounds.</p> <p>R102's hospice documentation did not include consistent documentation of his pressure wounds to include consistent measurements of the wound, description of the wound and peri-area, and progression of the wound. The facility staff did not follow-up with hospice and wound care providers to ensure they provided this documentation in order to properly monitor the progression of R102's wounds.</p> <p>On 01/29/25 at 01:11 PM Administrative Nurse D stated R102 received services from a hospice provider as well as a wound care physician for pressure wounds to his left and right buttocks. Administrative Nurse D stated she has had communication issues with the hospice nurse and has requested the wound care physician provide documentation.</p> <p>The administrator failed to ensure designated staff monitored the services provided by outside resources concerning R102's pressure wounds.</p> | S3105                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3155<br>SS=J                                                 | <p>26-41-204 (a) Health Care Services</p> <p>. (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>KAR 26-41-204(a)</p> <p>The facility reported a census of 51 residents. The facility identified 21 residents at risk for elopement and resided on a locked memory care unit. Based on observation, interview, and record review the administrator failed to ensure resident (R)102 was not subjected to neglect by the failure to ensure interventions for resident safety were monitored. This resulted in immediate jeopardy when cognitively impaired R102 exited the facility through his apartment window without staff knowledge and was unaccounted for by staff for approximately 30 minutes. This placed R102 in Immediate Jeopardy.</p> <p>Findings included:</p> <p>- R102's medical record revealed he moved into the facility on 04/24/24 with a diagnosis of Frontotemporal Neurocognitive Disorder.</p> | S3155                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3155                                                         | <p>Continued From page 13</p> <p>R102's "Functional Capacity Screen" (FCS) dated 04/22/24 revealed he was independent with transfers and mobility with the use of a walker, had a cognitive score of three indicating he was cognitively impaired with short-term memory, memory/recall and decision-making impairments.</p> <p>R102's "Negotiated Service Agreement" (NSA) did not include interventions for wandering, elopement risk or other behavioral symptoms.</p> <p>Review of the 07/01/24 at 08:15 PM "Nursing Note" documented, care staff found R102 walking on the sidewalk in front of the Lodge area at Cedar Lake Village (approximately 600 feet from R102's apartment.) Staff stated police arrived on campus and R102 sat in back of the police car. The police drove around the parking lot and returned R102 to the Memory Care Assisted Living entrance. The police checked R102's room and found the safety latch to be off the window.</p> <p>The "Facility Investigation Report" received by the State Agency on 07/03/24 documented on 07/01/24 R102 was upset during dinner and asked for his wife repeatedly. R102 was last seen entering his room after dinner at 05:55 PM. "Certified Medication Aide" (CMA) H noticed around 06:17 PM that R102 was not in his room and that the window was completely open with the screen removed. CMA H located R102 at approximately 06:25 PM on a sidewalk near the building. Upon investigation it was discovered R102's window was missing the safety feature which normally prevents the window from being</p> | S3155                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3155                                                         | <p>Continued From page 14</p> <p>opened all the way. After this was discovered, staff immediately removed all crank handles to the windows on the locked memory care unit and audited the windows for the presence of safety latches.</p> <p>On 01/29/25 at 12:51 PM an observation of R102's apartment windows revealed the safety latch was on the right-side window but was not attached at one end allowing the window to be opened fully. The latch was then reattached by maintenance staff. The window crank had been removed after the elopement incident so it could not be opened by R102.</p> <p>On 01/29/25 at 12:50 PM Maintenance Staff I stated R102 must have disabled the safety latch when he fought with the window causing a slide mechanism that locked the safety latch in place to come undone. Maintenance Staff I stated that prior to R102's elopement incident no safety audits were completed to ensure safety latches were intact on all windows located on the locked memory care unit.</p> <p>During an interview on 01/29/25 at 12:38 PM Administrative Staff A stated staff completed safety audits of the memory care unit windows and found that only R102's window did not have the safety mechanism in place. Administrative Staff A confirmed there were no safety audits on the windows prior to the elopement incident.</p> <p>During an interview on 01/29/25 at 02:46 PM Administrative Staff A stated video footage revealed no evidence R102 struggled to get the window open. R102 was able to open the window easily so it was assumed the safety latch slide</p> | S3155                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3155                                                         | <p>Continued From page 15</p> <p>was not engaged in a manner to prevent the window from opening.</p> <p>Observation on 01/29/25 at 11:45 AM revealed the facility was located on a large campus. There was an access road with a posted speed limit of 10 miles per hour (mph) circling the building with sidewalks and parking lots. To the west of the facility was a four-lane divided road with a posted speed limit of 45 mph. To the north was a large commercial area with numerous medical office buildings and a hospital. The road providing access to this area had a posted speed limit of 35 mph. To the south of the facility was a large pond and wooded area with a steep embankment. To the east of the facility past some campus housing units was a busy interstate.</p> <p>Weather conditions at the time of the elopement verified by <a href="https://www.wunderground.com">https://www.wunderground.com</a> revealed it was daylight outside, fair conditions, the temperature was approximately 79 degrees Fahrenheit, winds out of the Southeast at 15 mph.</p> <p>The facility failed to ensure R102 was not subjected to neglect, by the failure to ensure implementation of interventions for resident safety.</p> <p>Jeopardy was removed on 01/30/25 when the following actions were documented by the facility in the "Abatement Plan - Resident Elopement" and accepted by the department at 10:52 AM.</p> <p>1. The facility has worked with all involved parties to ascertain the following facts:</p> | S3155                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15325 S LONE ELM RD<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |
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| S3155                                                         | <p>Continued From page 16</p> <ul style="list-style-type: none"> <li>a. Resident in Memory Care Assisted Living began exhibiting agitation and elopement behaviors.</li> <li>b. Resident was somehow able to bypass safety measure on window, and used his own bed to<br/>scoot to window, open it fully and get out of secured area.</li> <li>c. Resident was located on-grounds approximately 10-min. later with no injury.</li> <li>d. There is no way to determine how long the safety latch was not functioning as intended.</li> </ul> <p>2. The facility has already provided the following as corrective action and means of prevention:</p> <ul style="list-style-type: none"> <li>a. All windows were audited immediately after event, on 07/01/24 to ensure all other windows were working as intended.</li> <li>b. All cranks were removed from windows on 07/01/24 in case resident was responsible for fault of window safety measure, and ensure this would not happen again.</li> <li>c. Elopement risk training modules are mandatory upon hire and renewed annually.</li> <li>d. Discussed elopement risk behaviors at nursing staff meetings on 07/02/24 &amp; 07/03/24.</li> </ul> <p>3. The facility will provide the following as corrective action and means of prevention:</p> <ul style="list-style-type: none"> <li>a. Provide immediate training resource document on HIPAA &amp; Privacy for staff (01/31/25) to read and sign off on prior to their next shift.</li> <li>b. Maintenance will conduct another inspection of all window units within secure wing of building, as well as an ongoing additional quarterly safety inspection beginning on 01/31/25 through 01/31/2026 for</li> </ul> | S3155                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3155                                                         | Continued From page 17<br><br>Memory Care to include all security doors<br>and windows.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | S3155                                                                                    |                                                                                                                          |                                                        |
| S3211<br>SS=E                                                 | 26-41-205 (g) (3) OVER THE COUNTER<br>DRUGS<br><br>(3) A licensed nurse or medication aide may<br>accept over-the-counter medication only in its<br>original, unbroken manufacturer ' s package. A<br>licensed pharmacist or licensed nurse shall<br>place the full name of the resident on the<br>package. If the original manufacturer ' s package<br>of an over-the-counter medication contains a<br>medication in a container, bottle, or tube that can<br>be removed from the original package, the<br>licensed pharmacist or a licensed nurse shall<br>place the full name of the resident on both the<br>original manufacturer ' s medication package and<br>the medication container.<br><br>This REQUIREMENT is not met as evidenced<br>by:<br>3211<br>KAR 26-41-205 (g)(3)<br><br>The facility reported a census of 20 residents.<br>Based on observation and interview the operator<br>failed to ensure a licensed pharmacist or<br>licensed nurse placed the full name of the<br>resident on the original package of over the<br>counter (OTC) medications for seven residents.<br><br>Findings included:<br><br>- Observation on 01/28/25 at 09:24 AM of the | S3211                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3211                                                         | <p>Continued From page 18</p> <p>Azalea House medication cart revealed the following OTC medications not labelled with the full name of the resident:<br/>One bottle Nature Made D3<br/>One bottle of Spring Valley Omega-2 1000 milligrams (mg.)<br/>One bottle of AZO Bladder Control<br/>One bottle of Tylenol Extra Strength</p> <p>Observation on 01/28/25 at 09:44 AM of the Briar House medication cart revealed the following OTC medications not labelled with the full name of the resident:<br/>Two bottles of Systane Completed eye drops.<br/>One bottle of Vitality Now Youthful Brain</p> <p>Observation on 01/28/25 at 10:06 AM of the Assisted Living (AL) medication cart #2 revealed the following OTC not labelled with the full name of the resident:<br/>One bottle of Refresh Tears<br/>One bottle of Cardiotabs Omega -3<br/>Two bottles of Cardiotabs Curcumin<br/>One bottle of Cardiotabs Bone Essentials</p> <p>Observation on 01/28/25 at 10:12 AM of AL medication cart #1 revealed the following OTC not labelled with the full name of the resident:<br/>One container of Metamucil Psyllium Fiber Supplement</p> <p>The 09/23/2024 "Medications Acquisition, Receiving, Packaging, and Storage" policy documented, "...the location is to ensure that OTC bottles/containers are labeled appropriately with the resident's full name."</p> <p>The administrator failed to ensure all OTC</p> | S3211                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3211                                                         | Continued From page 19<br><br>medications were labeled by a pharmacist or<br>licensed nurse with the resident's full name.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | S3211                                                                                    |                                                                                                                          |                                                        |
| S3261<br>SS=D                                                 | 26-41-105 (f) (11) Resident Record<br>Documentation of Incidents<br><br>(f) (11) documentation of all incidents, symptoms,<br>and other indications of illness or injury including<br>the date, time of occurrence, action taken, and<br>results of the action<br><br>This REQUIREMENT is not met as evidenced<br>by:<br>3261<br>KAR 26-41-105(f)(11)<br><br>The facility reported a census of 51 residents.<br>The sample included three residents and two<br>abbreviated record reviews. Based on interview<br>and record review the administrator failed to<br>ensure resident (R)102's medical records<br>contained documentation of all incidents,<br>symptoms, and other indications of illness or<br>injury including the date, action taken, and<br>results of the action related to pressure wounds.<br><br>Findings included:<br><br>- R102's medical record revealed he moved into<br>the facility on 04/24/24 with a diagnosis of<br>Frontotemporal Neurocognitive Disorder.<br><br>The 04/22/24 "Functional Capacity Screen"<br>(FCS) documented R102 was independent with | S3261                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3261                                                         | <p>Continued From page 20</p> <p>transfers and mobility, was occasionally incontinent of bladder and was unable to manage treatments.</p> <p>The 06/05/24 "Negotiated Service Agreement" (NSA) did not address management of treatments and staff assisted with incontinent products. There was no mention of services provided concerning the treatment of pressure wounds.</p> <p>The 11/05/24 "Interdisciplinary Progress Note" documented, " ...Resident has spot on left buttock measuring 0.1 centimeter (cm) x 0.2 cm x 0.0 cm."</p> <p>01/07/25 "Hospice Nursing Notes" documented the start of a wound on R102's backside, middle of two buttocks.</p> <p>01/09/25 "Communication Note" by Administrative Nurse D documented R102 had open areas on each buttock approximately the size of nickels. Nursing staff obtained an order for calmoseptine four times a day until healed due to current order of zinc oxide not being effective. Nurse will continue to monitor.</p> <p>01/14/25 "Hospice Nursing Notes" documented a physician was to assess R102's wounds.</p> <p>R102's medical records did not include consistent documentation of his pressure wounds to include consistent measurements of the wound, description of the wound and peri-area, and progression of the wound.</p> <p>On 01/29/25 at 01:11 PM Administrative Nurse D</p> | S3261                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3261                                                         | Continued From page 21<br><br>stated R102 had pressure wounds to his left and right buttocks and that R102 had a pressure wound on his buttocks when he admitted to the facility. Administrative Nurse D stated she did not measure R102's wounds because she thought the hospice nurse documented measurements.<br><br>The administrator failed to ensure designated staff included documentation of all incidents, symptoms and other indications of illness or injury including the dated, time of occurrence, action taken, and results of the action for R102 concerning pressure wounds.                                                                                                                                              | S3261                                                                                    |                                                                                                                          |                                                        |
| S3280<br>SS=F                                                 | 26-41-104 (d) Disaster and Emergency Preparedness<br><br>(d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following:<br>(1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;<br>(2) education of each resident upon admission to the facility regarding emergency procedures;<br>(3) quarterly review of the facility ' s emergency management plan with employees and residents; and<br>(4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.<br><br>This REQUIREMENT is not met as evidenced | S3280                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3280                                                         | <p>Continued From page 22</p> <p>by:<br/>3280<br/>KAR 26-41-104(d)(3)</p> <p>The facility reported a census of 51 residents. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan that included all eight required topics with employees and residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- On 01/29/25 Administrative Staff A provided a copy of the "Resident Council Minutes" for November 14, 2023, reviewing tornado evacuation procedures and July 16, 2024 reviewing fire safety. No other documentation was provided and there was no evidence that a review of the emergency management plan that included all eight required topics was reviewed with employees and residents on a quarterly basis.</li> </ul> <p>On 01/28/25 at 03:44 PM Administrative Staff A stated his practice was to review one seasonally relevant topic and encourage residents to review the emergency section of the handbook. He stated that he was not aware that all eight required topics needed to be reviewed on a quarterly basis.</p> <p>The administrator failed to ensure the completion of quarterly reviews covering all of the required</p> | S3280                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15325 S LONE ELM RD<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3280                                                         | Continued From page 23<br><br>items of the emergency management plan with<br>employees and residents.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | S3280                                                                                    |                                                                                                                          |                                                        |
| S3298<br>SS=F                                                 | 26-41-206 (d) Food Preparation<br><br>(d) Food preparation. Food shall be prepared<br>using safe methods that conserve the nutritive<br>value, flavor, and appearance and shall be<br>served at the proper temperature.<br>(1) Food used by facility staff to serve to the<br>residents, including donated food, shall meet all<br>applicable federal, state, and local laws and<br>regulations.<br>(2) Food in cans that have significant defects,<br>including swelling, leakage, punctures, holes,<br>fractures, pitted rust, or denting severe enough<br>to prevent normal stacking or opening with a<br>manual, wheel-type can opener, shall not be<br>used.<br>(3) Food provided by a resident ' s family or<br>friends for individual residents shall not be<br>required to meet federal, state, and local laws<br>and regulations.<br><br>This REQUIREMENT is not met as evidenced<br>by:<br>3298<br>KAR 26-41-206 (d)<br><br>The facility had a census of 51 residents. All 51<br>residents ate food prepared in the same kitchen.<br>Based on record review and interview, the<br>administrator failed to ensure food items were<br>served at the proper temperature.<br>Findings included: | S3298                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15325 S LONE ELM RD<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |
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| S3298                                                         | Continued From page 24<br><br>- Review of the January 2025 "Monthly Food Temperature Record" for the Briar House wing on the memory care unit revealed food temperatures were not documented on the following dates:<br>Breakfast-<br>01/03, 01/05<br>01/07- 01/08<br>01/10- 01/18<br>01/20- 01/21<br>01/24- 01/29<br><br>Noon-<br>01/03- 01/05<br>01/07- 01/08<br>01/10- 01/11<br>01/13- 01/21<br>01/24<br>01/27- 01/29<br><br>Evening-<br>01/02<br>01/06- 01/10<br>01/15- 01/16<br>01/18<br>01/21- 01/29<br><br>- Review of the January 2025 "Monthly Food Temperature Record" for the Azalea House wing on the memory care unit revealed food temperatures were not documented on the following dates:<br>Breakfast-<br>01/05- 01/08<br>01/10- 01/12<br>01/14<br>01/16- 01/29 | S3298                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15325 S LONE ELM RD<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |
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| S3298                                                         | Continued From page 25<br><br>Noon-<br>01/01<br>01/05- 01/08<br>01/11- 01/29<br><br>Evening-<br>01/04<br>01/06- 01/08<br>01/10<br>01/17- 01/22<br>01/25<br>01/27- 01/29<br><br>On 01/30/25 at 09:40 AM Dietary Manager J<br>stated food temperatures were completed prior to<br>transporting food to the memory care unit, and it<br>was the responsibility of the nursing staff on the<br>unit to re-temp the food before serving to the<br>residents.<br><br>The 02/2013 "Food Temperatures" policy<br>documented, "Food temperatures will be taken<br>and recorded before each meal service."<br><br>According to the Kansas Department of<br>Agriculture "Focus on Food Safety" revised<br>March 2024, hot foods must be maintained at an<br>internal temperature of 135 Fahrenheit (F) or<br>higher and cold foods must be maintained at an<br>internal temperature of 41 F or below.<br><br>The administrator failed to ensure food items<br>were served at the proper temperature. | S3298                                                                                    |                                                                                                                          |                                                        |
| S3299<br>SS=F                                                 | 26-41-206 (e) (1) Facility Food Storage<br><br>(e) Food storage. Facility staff shall store all<br>food under safe and sanitary conditions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | S3299                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CEDAR LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15325 S LONE ELM RD<br/>OLATHE, KS 66061</b> |                                                                                                                          |                                                        |
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| S3299                                                         | <p>Continued From page 26</p> <p>(1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>3299<br/>KAR 26-41-206(e)</p> <p>The facility had a census of 51 residents. All 51 residents ate food prepared in the same kitchen. The administrator failed to ensure food items were stored under safe and sanitary conditions by ensuring food was dated according to food safety guidelines and refrigerator and freezer temperatures were documented.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Observation of the assisted living satellite kitchen on 01/28/25 at 09:01 AM revealed a glass-doored refrigerator that contained two prepared salads covered with plastic wrap that were not dated or labeled.</li> </ul> <p>Observation of the Azalea House satellite kitchen on 01/28/25 revealed four identical plates of scrambled eggs, sausage and a muffin that were not covered but left open to air on the countertop.</p> <p>Review of the January 2025 "Refrigerator/Freezer Temperature Log" revealed temperatures were not documented on the</p> | S3299                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3299                                                         | <p>Continued From page 27</p> <p>following dates:</p> <p>Briar House Refrigerator-</p> <p>01/04- 01/05<br/>01/11- 01/12<br/>01/18- 01/19<br/>01/26</p> <p>Briar House Freezer-</p> <p>01/04- 01/05<br/>01/11- 01/12<br/>01/18- 01/19<br/>01/26</p> <p>Azalea House Refrigerator-</p> <p>01/04- 01/07<br/>01/11- 01/12<br/>01/18- 01/19<br/>01/25- 01/26</p> <p>Azalea House Freezer-</p> <p>01/04- 01/07<br/>01/11- 01/12<br/>01/18- 01/19<br/>01/25- 01/26</p> <p>The March 2024 "Focus on Food Safety"<br/>published by the Kansas Department of<br/>Agriculture states food, "Must be date marked if it<br/>is prepared on-site... ready-to-eat...Held for more<br/>than 24 hours. Mark the date by which food is to<br/>be consumed or discarded..."</p> <p>The undated "AL/MCAL Temperature Log" policy<br/>documented, "Each refrigerator and freezer must<br/>be temperature checked once every 24 hours on<br/>the night shift ...A temperature log for each<br/>day/month is in a Temperature Log Notebook.</p> | S3299                                                                                    |                                                                                                                          |                                                        |

Kansas Department on Aging

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| S3299                                                         | Continued From page 28<br><br>Check temperature and write in notebook."<br><br>The administrator failed to ensure food items<br>were stored under safe and sanitary conditions. | S3299                                                                       |                                                                                                                          |                          |                                                        |