STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #185287, #184167, #183191, #181979, #179514, #177794 at the above named assisted living conducted on 05/22/24 and 05/23/24.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 30 residents with three residents included in the sample and three closed record reviews. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Residents (R) 1, R2, and R5 described the	S3085		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3085	Continued From page 1	S3085		

services they received based on their "Functional Capacity Screens" (FCS). The operator further failed to ensure the "NSA" for R2 identified the provider for outside services including a description of services they provided.

Findings included:

- Record review for R1 revealed an admission date of 03/29/23 with a diagnosis of heart failure.

The 03/16/23 "FCS" identified R1 required physical assistance for toileting and was marked for falls.

The 04/01/23 "NSA" identified R1 managed her own toileting needs. The "NSA" failed to describe services provided to R1 for toileting and to prevent injury from falls.

On 05/23/24 at approximately 11:37 AM Administrative Nurse B confirmed R1's "NSA" failed to describe the services provided for toileting and to prevent injury from falls.

- Record review for R2 revealed an admission date of 09/14/23 with a diagnosis of history of falling.

The 09/19/23 "FCS" identified R2 was at risk for falls.

The 09/14/23 "NSA" failed to describe services provided R2 to prevent injury from falls. The "NSA" failed to identify the outside provider for hospice services and describe the services they provided.

On 05/23/24 at approximately 11:37 AM Administrative Nurse B stated R2 was admitted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3085	Continued From page 2 hospice and confirmed her "NSA" failed to identify the hospie provider and failed to describe the services they provided. - Record review for R5 revealed an admission date of 04/25/23 with a diagnosis Alzheimer's Disease. The 09/18/23 "FCS" identified R5 was rarely or never understandable and rarely or never understood during communication. The 09/19/23 "NSA" failed to describe services provided R5 for inability to communicate. On 05/23/24 at 01:14 PM Administrative Nurse B confirmed R5's "NSA" failed to describe services provided for communication. The facility's 12/01/23 "Care Plan" policy documented the "NSA" should address all possible areas of need and preferred services. The operator failed to ensure R1, R2, and R5's "NSAs" described the services they received based on their "FCS." The operator further failed to ensure the "NSA" for R2 identified the provider for outside services including a description of services they provided.	S3085		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative.	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 30 residents with three residents included in the sample and three closed record reviews. Based on interview and record review the operator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 3. Findings included: - Record review for R3 revealed an admission date of 09/14/23 with a diagnosis of type two diabetes mellitus. The 09/19/23 "Functional Capacity Screen" (FCS) identified R13 required physical assistance with bathing; was unable to perform management of medications and treatments; was frequently incontinent of bladder; and had short-term memory, memory recall, and decision-making difficulties. The 09/14/23 "Negotiated Service Agreement" NSA identified facility staff provided physical assistance with bathing; management of medications and treatments; assistance as needed for bladder incontinence; and redirection as needed and reminders to meals and activities for cognitive difficulties. The 09/14/23 "NSA" lacked signature by R3's legal representative. On 05/23/24 at 12:57 PM Administrative Nurse B confirmed R3's "NSA" lacked a signature by R3's	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3101	Continued From page 4 legal representative. The facility's 12/01/23 "Care Plan" policy documented the resident or their designated agent should review and sign the "NSA." The operator failed to ensure that each individual involved in the development of the "NSA" signed the agreement for R3.	S3101		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The facility reported a census of 30 residents with three included in the sample and three closed record reviews. Based on observation, interview, and record review the operator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for Residents (R) 4. The operator further failed to ensure a gap greater than 4.5 inches between the rails of a bed assist device was covered to prevent entrapment. Findings included: - Record review for R4 revealed an admission	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 5 date of 09/16/23 with a diagnosis of chronic kidney failure. The 12/28/23 "Functional Capacity Screen" (FCS) identified R4 was independent with transfers and was marked for falls. The 03/22/24 "Negotiated Service Agreement" (NSA) identified R4 was independent with transfers and facility staff provided encouragement to call for assistance when feeling unsteady to prevent injury from falls. R4's record lacked evidence of documentation of a bed assist device assessment. Observation on 05/23/24 at 10:58 AM revealed a bed assist device was attached to the right side of R4's bed. There was a 12-inch gap between the rails of the bed assist that lacked a cover to prevent entrapment between the rails. On 05/23/24 at approximately 10:58 AM R4 stated she used the bed assist device to help her get and in and out of bed. On 05/23/24 at approximately 11:37 AM Administrative Nurse B confirmed R4's record lacked evidence of documentation a bed rail assessment was completed. On 05/15/24 at approximately 12:20 PM Administrative Nurse C confirmed R5's record lacked evidence of documentation a bed rail assessment was completed. The operator failed to ensure a licensed nurse completed an assessment for the purpose to use a bed assist device, ability to use a bed assist safely without risk of entrapment, and to confirm the bed assist device was not a restraint for R4.	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3171	Continued From page 6 The operator further failed to ensure a gap greater than 4.5 inches between the rails of a bed assist device was covered to prevent entrapment.	S3171		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 30 residents with three included in the sample and three closed record reviews. Based on interview and record review the operator failed to ensure a licensed nurse performed an assessment to determine if Resident (R) 6 could self-administer insulin safely.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046042	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING OF MISSION SPRINGS I	5300 W 61ST PLACE MISSION, KS 66205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3175	Continued From page 7 Findings included: - Record review for R6 revealed an admission date of 05/10/23 with diagnoses of Alzheimer's Disease and type two diabetes mellitus. The 10/30/23 "Functional Capacity Screen" (FCS) identified R6 was unable to perform management of medications. The 10/31/23 "Negotiated Service Agreement" (NSA) identified facility staff assisted R6 with insulin administration. R6's record lacked evidence of documentation a medication self-administration assessment to administer insulin was completed. On 05/23/24 at 01:30 PM Administrative Nurse B confirmed R6's lacked evidence of documentation a medication self-administration assessment to administer insulin was completed. The facility's undated "Self-Administering Medications Policy" documented a resident may self-administer medications after the nurse completed a self-medication evaluation to determine if the resident was capable of self-administration of medications. The operator failed to ensure a licensed nurse performed an assessment to determine if R6 could self-administer insulin safely.	S3175		