STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA ROAD OVERLAND PARK, KS 66213

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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey with attached complaint #'s 172181, 168643, 165711 and 163176 for the above named facility conducted on 6/21/2022 and 6/22/2022.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (a) The facility reported a census of 34 residents. The sample included 3 residents (R). Based on record review and interview, the operator failed to ensure a licensed nurse conducted a screening prior to or at the time of admission for R1, to determine his level of functional capacity and failed to ensure the findings were recorded on a screening form specified by the department.	S3080		

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

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S3080	Continued From page 1	S3080		

Findings included:

06/21/22 record review for R1 revealed an admission date of 06/14/22, with a diagnosis of senile degeneration of the brain.

The record lacked documentation of a functional capacity screen.

06/21/22 record review of the facility document titled "Nursing admission/readmission evaluation V-1" revealed the following items marked:
No impaired skin integrity
No problems with nutrition
He was orientated to person
His speech was understood
He was not incontinent of bladder
He used the toilet
He wore incontinent briefs
The section titled "Bladder Continence Needs" was left blank
The resident did not have unsteady gait
The "Fall Prevention Needs" section was blank
The "At Risk for Falls" section was blank
The "Elopement" section marked the resident as cognitively impaired and independently mobile.
The resident had an active mental illness and resided in a secured unit.
The section marked "Self-Sdministration of Medications" was marked as the facility would be responsible for all medications.

Record review of the "Electronic Progress Notes dated 06/14/22 to 06/21/22 revealed the following entries:

06/14/22 at 02:47 PM revealed the resident arrived per private vehicle with a diagnoses of senile degeneration of the brain. Resident was admitted to hospice with no known allergies and

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S3080	Continued From page 2	S3080		

medications were verified per hospice.
06/15/22 at 04:20 AM revealed the esident was very anxious and confused this shift. He wandered the hallway and was very hard to redirect.
06/16/22 at 02:53 PM revealed constant elopement attempts were made by the resident. Staff were not able to redirect and the resident hit at staff. The resident spit his as needed medication out.
06/16/22 at 08:55AM revealed at approximately 04:20 PM the resident bled from his right ring finger and could not explain how he got cut. Resident had constant behavior, trying to elope or entering other residents' apartments. Staff had to provide one on one supervision for a while. The resident went to the courtyard flipping the tables and chairs and trying to pull the flowers. Staff brought him in and sat with him. The resident kneeled on the floor, crawled and staff again got him up and put him in the recliner to watch television.
06/17/22 at 10:46 PM revealed the resident had an unwitnessed fall.
06/20/22 at 01:00 PM revealed the residnet had an unwitnessed fall.

Interview 6/22/2022 at 10:35 AM with Operator D and Licensed Nurse E confirmed the resident record lacked a screening document determining R1 level of functional capacity.

The operator failed to ensure a licensed nurse conducted a screening prior to or at the time of admission for R1, to determine his level of functional capacity and failed to ensure the findings were recorded on a screening form specified by the department.

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S3090	Continued From page 3	S3090		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (c) The facility reported a census of 34 residents. The sample included 3 residents (R). Based on record review and interview, the operator failed to ensure the development of an initial written negotiated service agreement for R1 at the time of admission, which was based on R 1's functional capacity screen, service needs and preferences in collaboration with the resident's legal representative. Findings included: 06/21/22 record review for R1 revealed an admission date of 06/14/22, with a diagnosis of senile degeneration of the brain. The record lacked documentation of a functional capacity screen. 06/21/22 record review of the facility document titled "Nursing Admission/Readmission Evaluation V-1" revealed the following items marked: No impaired skin integrity No problems with nutrition He was orientated to person His speech was understood	S3090		

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S3090	Continued From page 4	S3090		

He was not incontinent of bladder
He used the toilet
He wore incontinent briefs
The section titled "Bladder Continence Needs" was left blank
The resident did not have unsteady gait
The "Fall Prevention Needs" section was blank
The "At Risk for Falls" section was blank
The "Elopement" section marked the resident as cognitively impaired and independently mobile.
The resident had an active mental illness and resided in a secured unit.
The section marked "Self-Sdministration of Medications" was marked as the facility would be responsible for all medications.

Record review of the "Electronic Progress Notes dated 06/14/22 to 06/21/22 revealed the following entries:

06/14/22 at 02:47 PM revealed the resident arrived per private vehicle with a diagnoses of senile degeneration of the brain. Resident was admitted to hospice with no known allergies and medications were verified per hospice.
06/15/22 at 04:20 AM revealed the esident was very anxious and confused this shift. He wandered the hallway and was very hard to redirect.
06/16/22 at 02:53 PM revealed constant elopement attempts were made by the resident. Staff were not able to redirect and the resident hit at staff. The resident spit his as needed medication out.
06/16/22 at 08:55AM revealed at approximately 04:20 PM the resident bled from his right ring finger and could not explain how he got cut. Resident had constant behavior, trying to elope or entering other residents' apartments. Staff had to provide one on one supervision for a while. The

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S3090	Continued From page 5 resident went to the courtyard flipping the tables and chairs and trying to pull the flowers. Staff brought him in and sat with him. The resident kneeled on the floor, crawled and staff again got him up and put him in the recliner to watch television. 06/17/22 at 10:46 PM revealed the resident had an unwitnessed fall. 06/20/22 at 01:00 PM revealed the residnet had an unwitnessed fall. The record lacked a document titled Negotiated Service Agreement providing a description of services and the provider of each of the services, which were identified in R1 electronic progress notes for the following services: clinical treatment of wounds, interventions for falls, interventions for inappropriate behaviors, and the outside provider of hospice. Interview 06/22/22 at 10:35 AM with Operator D and Licensed Nurse E confirmed the resident record lacked a document titled Negotiated Service Agreement. The operator failed to ensure the development of an initial written negotiated service agreement for R1 at the time of admission, which was based on R 1's functional capacity screen, service needs and preferences in collaboration with the resident's legal representative.	S3090		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (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	S3092		

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S3092	Continued From page 6 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d) (2) The facility reported a census of 34 residents. The sample included 3 resident's (R) (101, 102 and 103). Based on record review and interview the operator failed to ensure review and when necessary the revision of the negotiated service agreement for R102 identifying the description of services the resident would receive, identification of the provider for the services, and identification of each responsible party for services being provided. Findings included: - Record review for R102 revealed an admission date of 02/07/22 with diagnoses of wedge compression fracture, unspecified fall, cognitive impairment, history of falling, difficulty in walking, type 2 diabetes, major depressive disorder, personal history of transient ischemic attack and cerebral infarction without residual deficits. Record review of the "Functional Capacity Screening" (FCS) dated 05/10/22 revealed the	S3092		

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S3092	Continued From page 7	S3092		

resident required physical assistance with bathing, dressing, and toileting. He required supervision for transferring and lacked the ability to manage his own medications. He had impaired short term, long term, memory recall, and decision making. He used a wheelchair for mobility and was not marked as a fall risk.

Record review of the combined "Negotiated Service Agreement (NSA)/Healthcare Service Plan(HSP)" dated 05/10/22, identified/instructed the facility staff to participate in activities that would increase strength and mobility, check or resident at frequent intervals and offer assistance, administer medications, provide minimal assistance with bathing and toileting. Staff to provide extensive assistance with dressing, and supervision or cues with transferring. The document lacked any entry for physical, occupational or speech therapies.

Record review of the "Electronic Progress Notes" dated 02/07/22 to 06/16/22 revealed the following entries:
02/07/22 at 08:15 PM revealed the resident arrived at the memory care unit at approximately 03:30 PM with reccomendations for physical therapy, occupational therapy, and speech therapy.
02/26/22 at 12:38 PM called to the resident's room by a certified nursing assistant. Upon entering the room the resident was observed on the floor positioned on his back.
04/08/22 at 01:07 PM revealed the residnet complained of pain to the coccyx.
04/20/22 at 06:35AM revealed the resident had a fall around 03:50 AM.
06/10/22 at 11:11 AM revealed the resident's family member reported therapy requested the resident get a new wheelchair.

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S3092	Continued From page 8 Interview on 06/22/22 at 10:35 AM with Operator D and Licensed Nurse E, they confirmed the negotiated service agreement lacked the documentation providing a description of the physical therapy services, the provider of the physical therapy services, and the responsible party for the physical therapy services. The operator failed to ensure review and when necessary the revision of the negotiated service agreement for R102 identifying the description of services the resident would receive, identification of the provider for the services, and identification of each responsible party for services being provided.	S3092		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused,	S3248		

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neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-102 (d)(3)

The facility reported a census of 34 residents. The sample included 3 residents and 5 newly hired staff. Based on interview and record review the operator failed to ensure the newly hired employee records contained proof of supporting documentation from the Kansas nurse aide registry for 2 newly hired certified medication aides (CMA's) (B and C) showing the individuals did not have a finding of abuse, neglect or exploitation of a resident in an adult care home prior to providing care to all residents.

Findings included:

- Record review on 06/22/22 for newly hired CMA B revealed a hire date of 09/17/21. The personnel record lacked documentation from the Kansas Nurse Aide Registry.

Record review on 6/22/2022 for newly hired CMA C revealed a hire date of 01/17/22. The personnel record lacked documentation from the Kansas Nurse Aide Registry.

06/22/22 at approximately 12:00 PM with Facility Staff A, he confirmed the personnel records for CMA's B and C lacked the documentation from

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S3248	Continued From page 10 the nurse aide registry showing the individuals did not have a finding of abuse, neglect or exploitation of a resident in an adult care home prior to providing care to residents. The operator failed to ensure the newly hired employee records contained proof of supporting documentation from the Kansas nurse aide registry for newly hired personnel showing the individuals did not have a finding of abuse, neglect or exploitation of a resident in an adult care home prior to providing care to all residents.	S3248		