Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046071	A. BUILDING: _____ B. WING _____	06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints (#176965, #174885, #174112, #173921, #173196, #171344, #168017, #167612) at the above named facility conducted on 06/19/23 and 06/20/23.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

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

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S3028	Continued From page 1	S3028		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-101(f) (3)

The facility reported a census of 78 residents. The sample included 6 residents and 1 closed record review resident. Based on record review and interviews for 1 closed record review Resident (R)7, Administrator A failed to ensure each incident of potential exploitation was thoroughly investigated when accusations of missing narcotics were made.

Findings included:

- R7's "Medical Record" revealed he admitted to the facility on 03/23/06 with diagnoses of hyperlipidemia, major depressive disorder, age-related osteoporosis, atrial fibrillation and angina pectoris.

The "Resident Functional Capacity Screen" (FCS) dated 06/30/22 recorded the resident as independent with management of medications and treatments.

The "Service Plan" dated 05/09/22 recorded R7 self-administered his medications.

Reports indicated resident had Morphine (narcotic) and Ativan (sedative) in his room, brought in by a hospice nurse for self-administration, and medication was missing.

Interview on 06/20/23 at 01:30 PM with

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S3028	Continued From page 2 Administrator A confirmed an accusation of missing medications including resident's Morphine injections was made by R7's family member on 07/04/22 and she failed to conduct a documented investigation of accusation. Nurse's Note dated 07/02/22 recorded, "Resident has experienced some confusion today. He has had a decrease in appetite and self-administered Morphine [narcotic for pain], which has made him sleep for most of the day. Daughter visiting with resident currently as well as with hospice." Signed by Licensed Nurse (LN) E. Record lacked a nurse's note regarding accusation of missing narcotics. Record lacked a completed investigation of the accusation by facility. Interview on 06/20/23 at 01:30 PM with Administrator A confirmed residents were not able to self-administer narcotics, including hospice narcotics, and further confirmed narcotics were not to be left in resident's room. Electronic interview on 06/26/23 at 09:29 AM with Administrator A confirmed narcotic records for Morphine and Ativan for R7 were not completed by facility. Facility's "Medication Oversight Program" policy dated 04/23 recorded, "1. Storage: Controlled substance are stored in a double locked cabinet. Controlled substances needing refrigeration are stored in a locked box within a locked medication refrigerator."	S3028		

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S3028	Continued From page 3 Administrator A failed to ensure each incident of potential exploitation was thoroughly investigated when accusations of missing narcotics were made.	S3028		
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 census equaled 78 residents. The sample included 6 residents. Based on record review and interview, Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice, which met the needs of 1 sampled Resident (R)5. Findings included: - R5's "Medical Record" revealed he admitted to the facility on 02/25/22 with diagnoses of Parkinson's disease, hyperlipidemia, hypertension, and peripheral vascular disease. The "Resident Functional Capacity Screen" (FCS) dated 02/25/22 recorded the resident as unable to perform management of medications and treatments.	S3171		

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S3171	Continued From page 4 The "Service Plan" dated 02/25/22 recorded facility staff managed and administered medications to R5. Signed physician orders dated 02/23/22 recorded, "Carbidopa-Levodopa [Parkinson's medication] 25-100 milligram tablet (oral) three times daily for 90 days. Start Date: 01/08/22" and "Xarelto [blood thinner] 20 milligram tablet (oral) daily for 90 days. Start Date: 01/08/22." Record lacked evidence signed physician orders were confirmed by a licensed nurse for administration in facility upon 02/25/22 admission. Review of R5's "Progress Notes" revealed no nurse's note completed upon admission on 02/25/22. Review of April 2022 MAR (medication administration record) recorded, "Xarelto Tablet 20 milligram (Rivaroxaban) Give 1 tablet by mouth one time a day for anticoagulant until 04/08/22 11:59 PM- Start Date- 02/26/22 07:00 AM." Xarelto not administered from 04/09/22 to 04/28/22. Review of April 2022 MAR recorded, "Carbidopa-Levodopa 25-100 milligram Give 1 tablet by mouth three times a day for Parkinson's disease until 04/08/22 11:57 AM- Start Date- 02/25/22 01:00 PM." Carbidopa-Levodopa not administered from 04/08/22 at 01:00 PM to 04/27/22 at 04:00 PM. Record lacked evidence facility monitored R5 for	S3171		

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S3171	Continued From page 5 side effects of stopping Carbidopa-Levodopa and Xarelto. Interview on 06/20/23 at 03:00 PM with Administrator A confirmed record lacked evidence a licensed nurse confirmed physician orders prior to start of facility administration of medication on 02/25/22, an admission nurse's note on 02/25/22 and evidence of side effects monitored from stopping medication. Facility's "Medication Oversight Program" policy dated 04/23 recorded, "Medication oversight: The residential care director and wellness team review eMAR [electronic medication administration record]/ Orders Dashboard and Orders Portal in SCC on a per-shift, daily, weekly, bi-weekly and monthly schedule to oversee medication management activities in the community ... A. Chart checks 1. Weekly medication cart checks: Medication carts and paper MARs are expected to be checked weekly using Weekly MAR/Medication Cart Checks form available on TeamLink." Administrator A failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services in accordance with acceptable standards of practice, which met the needs of 1 sampled Resident (R)5.	S3171		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall	S3211		

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place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-205 (g) (3)

The census totaled 78 residents. The sample included 6 residents. Based on observation and interview for 1 sampled Resident (R)3 and 9 non-sampled Residents (R)8, R9, R10, R11, R12, R13, R14, R15, R16, Administrator A failed to ensure licensed nurses or pharmacists placed the full name of the resident on each package of the resident's over the counter medication.

Findings included:

- Observation on 06/19/23 at 01:04 PM with Licensed Nurse (LN) C revealed a locked medication cart on the first floor in the facility. The following over the counter medications were noted without full names:

For R8 the cart contained one bottle of Aspirin (nonsteroidal anti-inflammatory drug) and one bottle of Vitamin D3 (supplement),
For R9 the cart contained one bottle of Antacid, one bottle of Ibuprofen (non-steroidal

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anti-inflammatory drug) and six bottles of Multivitamins,
For R10 the cart contained one bottle of Tylenol (pain reliever/ fever reducer),
For R11 the cart contained one bottle of AREDS 2 (eye vitamin and mineral supplement).

Interview on 06/19/23 with LN C confirmed the above listed medications were without full first and last names for R8, R9, R10 and R11.

- Observation on 06/19/23 at 02:26 PM with Licensed Nurse (LN) C revealed a locked medication cart on the second floor in the facility. The following over the counter medications were noted without full names:

For R12 the cart contained one bottle of AZO Cranberry (supplement), one bottle of Vitamin D3 (supplement) and one bottle of Tylenol (pain reliever/ fever reducer),
For R13 the cart contained one bottle of Aspirin (nonsteroidal anti-inflammatory drug),
For R3 the cart contained one bottle of Vitamin D3.

- Observation on 06/19/23 at 02:39 PM with Licensed Nurse (LN) C revealed a locked medication cart on the second floor in the facility. The following over the counter medications were noted without full names:

For R14 the cart contained one bottle Tylenol (pain reliever/ fever reducer), one bottle of ClearLAX (laxative), one bottle of Complete Multivitamin, and one bottle of Acetaminophen (pain reliever/ fever reducer),
For R15 the cart contained one bottle Tylenol

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S3211	Continued From page 8 Extra Strength, For R16 the cart contained one bottle Vitamin C (supplement), one bottle of Zinc (supplement), one bottle of Vitamin B12 (supplement) and one bottle of Aspirin (nonsteroidal anti-inflammatory drug). Interview on 06/19/23 with LN C confirmed the above listed medications were without full first and last names for R12, R13, R3, R14, R15 and R16. Facility's "Medication Oversight Program" policy dated 04/23 recorded, "D. Medication Storage: Medications are stored in a safe, secure manner according to manufacturer's recommendations and applicable laws/ regulations." Administrator A failed to ensure licensed nurses or pharmacists placed the full name of residents on each package of the resident's over the counter medication.	S3211		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and	S3280		

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S3280	Continued From page 9 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3) The census equaled 78 residents. The sample included 6 residents and review of 5 employee records. Based on record review and interview, Administrator A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with residents and staff. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. Review of the facility's quarterly reviews of the emergency management plan with residents revealed reviews completed upon each resident's admission to facility. The facility failed to provide documentation regarding emergency management plan reviews with all residents for the first, second, third and fourth quarters of 2022 and the first quarter of 2023.	S3280		

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S3280	Continued From page 10 Review of the facility's quarterly reviews of the emergency management plan with staff revealed the following review dates: 04/20/23 The facility failed to provide documentation regarding emergency management plan reviews with staff for the first, second, third and fourth quarters of 2022 and the first quarter of 2023. Interview on 06/19/23 at 04:55 PM with Administrative Staff D confirmed unable to locate reviews completed with staff for the first, second, third and fourth quarters of 2022 and the first quarter of 2023. Interview on 06/20/23 at 09:57 AM with Administrator A confirmed reviews of the emergency management plan were completed upon each resident's admission to the facility and further confirmed they were not completed quarterly with residents. Administrator A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with residents and staff.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and	S3298		

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regulations.
(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used.
(3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-206 (d)

The census equaled 78 residents. Based on record review and interview for all residents living in the facility and receiving meal services, Administrator A failed to ensure the facility staff served food at the proper temperature.

Findings included:

- During the initial tour on 06/19/23, facility food temperature monitoring logs were requested on the first floor in the main kitchen where meals were prepared and served to residents. "Production Summary Worksheet with Temperatures" were obtained for May 2023 and June 2023 from Administrator A.

Record lacked breakfast food temperatures for the following dates:
05/01/23 through 05/31/23, 06/01/23 through 06/10/23, 06/12/23, 06/13/23, 06/15/23, 06/16/23

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S3298	Continued From page 12 and 06/17/23. Record lacked lunch food temperatures for the following dates: 05/01/23 through 05/31/23 and 06/01/23 through 06/18/23. Record lacked supper food temperatures for the following dates: 05/01/23 through 05/31/23, 06/01/23 through 06/05/23 and 06/07/23 through 06/13/23, 06/15/23, 06/16/23 and 06/17/23. Interview on 06/19/23 at 05:00 PM in the first-floor dining room with Resident (R)17, who was eating supper time meal, stated food served is never hot. Interview on 06/20/23 at 02:36 PM with Administrator A confirmed food temperatures were to be taken at each breakfast, lunch and supper meal and further confirmed the May 2023 and June 2023 "Production Summary Worksheet with Temperatures" lacked breakfast, lunch and supper food temperatures conducted at each meal for the above listed dates. Kansas Department of Agriculture Food Safety guidelines records hot food must be maintained at a temperature of 135 degrees Fahrenheit or above, cold foods at 41 degrees Fahrenheit or below. Facility's "Food Temperatures" policy dated 03/19/20 recorded, "Foods shall be served at proper temperature to ensure food safety and palatability ... 3. Record reading on Food Temperature Chart or Food	S3298		

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S3298	Continued From page 13 Temperature/Sanitation Combined Record and/or Always Available Food Temperature Chart or other designated form at beginning of tray line and end of tray line." For all residents of the facility, Administrator A failed to ensure facility staff served food at the proper temperature.	S3298		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The census totaled 78 residents. The sample included 6 residents and review of 5 newly hired employees. Based on record review and interview for 6 of 6 sampled Residents (R)1, R2, R3, R4, R5 and R6, the facility failed to ensure	S3310		

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(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
S3310	Continued From page 14 compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - R1's "Health Record" revealed she admitted to the facility on 07/13/20 and the record lacked completion of an annual TB questionnaire. R2's "Health Record" revealed she admitted to the facility on 11/04/19 and the record lacked completion of an annual TB questionnaire. R3's "Health Record" revealed she admitted to the facility on 03/26/21 and the record lacked completion of an annual TB questionnaire. R4's "Health Record" revealed she admitted to the facility on 11/06/22 and the record lacked completion of a TB questionnaire upon admission. R5's "Health Record" revealed he admitted to the facility on 02/25/22 and the record lacked evidence of completion of the second step of the TB testing and a TB questionnaire upon admission. R6's "Health Record" revealed he admitted to the facility on 03/06/23 and the record lacked evidence of completion of the second step of the TB testing and a TB questionnaire upon admission. Interview on 06/20/23 at 02:01 PM with Licensed Nurse (LN) B confirmed unable to locate an annual TB questionnaire completed for R1, R2 and R3.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046071	A. BUILDING: _____ B. WING _____	06/20/2023

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S3310	Continued From page 15 Interview on 06/20/23 at 02:04 PM with LN B confirmed unable to locate the second step of TB testing for R5 and R6 and further confirmed unable to locate a TB questionnaire completed upon admission for R4, R5 and R6. Facility's TB guidelines (no title) (no date) recorded, "Each new resident and new employee shall have an initial TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within 7 days of residency." The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		