STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046087	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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 represent the findings of an abbreviated survey with review of facility report #183724 at the above assisted living conducted on 11/06/23.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(A) The facility reported a census of 21 residents with one resident included in the sample. Based on observation, interview, and record review the administrator failed to protect one resident from abuse when a staff member slapped Resident (R) 1 in the face resulting in a skin tear on her left cheek and R1 became afraid she was going to be hurt again. This failure placed R1 in immediate jeopardy. Findings included: - Record review for R1 revealed an admission date of 10/02/23 with a diagnosis of dementia	S3026		

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
	N046087	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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
S3026	Continued From page 1	S3026		

with behaviors.

The 10/02/23 "Functional Capacity Screen" (FCS) identified R1 required supervision with bathing and walking/mobility; physical assistance with dressing, toileting, transfers using a gait belt; was unable to perform management of medications and treatments; and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties.

The 10/02/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; daily assistance for management of medications; routine vitals and wellness checks for management of treatments; and she was able to make her needs known for cognitive difficulties.

The 10/14/23 "Progress Note" by CMA C documented R1 was in her room "screaming and yelling." She threatened staff with verbal comments.

The 10/15/23 "Progress Note" by CMA C documented R1 requested to go the bathroom more often than normal. She yelled for staff to assist her to the bathroom and asked residents to assist her to the bathroom.

The 10/16/23 "Progress Note" by CMA C documented R1 was combative and verbally abusive to staff making it difficult to care for the other residents. R1 screamed, yelled, hit, kicked, and used racial slurs.

The 10/27/23 "Nursing Progress Note" by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046087	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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
S3026	Continued From page 2	S3026		

Administrative Nurse B documented R1 stated a Certified Medication Aide (CMA) slapped R1across the face. R1 provided an accurate description of CMA C. R1 stated she was in the public bathroom and CMA C wanted to help her, but she did not need help. When she told CMA C she did not need any help CMA C hit her across the left side of her face. She went back to her apartment and was afraid CMA C would come into her apartment. Skin assessment revealed a skin tear to left side of her face with discoloration and a bruise on the top of her right hand. R1's Durable Power of Attorney (DPOA), her medical provider, and hospice nurse were notified of the incident.

The 10/27/23 "Witness Statement" by CMA C documented while the other caregiver on duty was on break, she saw R1 stand up and push her wheelchair toward the bathroom. CMA C offered to help and R1 refused help and told CMA C to leave her alone. CMA C was able to calm R1 enough to assist her to sit on the toilet. R1 yelled that she did not want help and swung at CMA C's head while CMA C assisted to put on a new incontinence brief. R1's hand "glazed" her own face. CMA C had documented R1's combative behavior several times in her Electronic Health Record (EHR).

The undated "Witness Statement by Certified Nurse Aide (CNA) D documented R1 approached her in the common area, pointed toward CMA C, and reported CMA C slapped her. R1 showed CNA D a skin tear on the side of her face that was bleeding. R1 reported she did not feel safe going back to her room because she was afraid CMA C would hurt her while she was trying to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046087	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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
S3026	Continued From page 3	S3026		

sleep.

The 11/06/23 notarized "Witness Statement" by Administrative Nurse B documented it was reported to her at 12:25 PM that R1 stated a CMA slapped her face. Administrative Nurse B arrived at the facility at approximately 01:30 PM and went to R1's apartment. R1 was lying in bed and pointed to her face and said, "Do you see what that woman did to me?" There was a skin tear to R1's face that measured 1.5 centimeters (cm) in length surrounded by reddish discoloration. A statement was obtained from CMA C, she was escorted out of the facility, and placed on suspension.

Review of the facility's Abuse, Neglect, and Exploitation training revealed CMA C was provided training on 07/20/23 and 10/12/23.

The 07/18/23 Kansas Department for Aging and Disability Services background check report for CMA C revealed there was no documentation of any criminal history.

Review of the facility's staffing schedule for October and November 2023 revealed CMA C worked day shift up to 10/27/23. She was not listed on the schedule after 10/27/23.

Observation on 11/06/23 at 03:08 PM revealed R1 propelled herself in the hallway to her apartment. An approximately 1.0 cm long scab surrounded by light redness was visible on her left cheek.

On 11/06/23 at 01:19 PM Administrative Nurse B stated R1 had acted out before but had never

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046087	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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
S3026	Continued From page 4	S3026		

physically attacked staff.

On 11/06/23 at 01:54 PM Administrative Nurse B confirmed CMA C documented R1 exhibited combative behaviors in the electronic health record.

On 11/06/23 at 03:08 PM R1 stated "The lady that used to work here was mean as the devil." She stated CMA C at her down in a chair and told her to sit there. R1 decided she was not going to let CMA C tell her what to do and she tried to go the toilet. The CMA pushed her back down in the chair and slapped her face. She shoved her on the toilet stool and slapped her again. The CMA had long fingernails that cut her face. R1 stated "I never did anything wrong." The CMA was mean to everybody and was fired.

On 11/06/23 at 03:26 PM R2 stated he felt safe living in the facility. The staff were nice, and no one had ever been mean or rude to him.

On 11/06/23 at 03:33 PM R3 stated she had been nice to her since she moved in. No one had been mean or rude and she had never witnessed staff abusing other residents. She felt safe living in the facility so far.

On 11/06/23 at approximately 04:13 PM Administrative Nurse B stated CMA C was suspended and escorted out of the building on 10/27/23 between 01:30 and 02:00 PM. The CMAs were supposed to chart in residents' EHR's but no other staff charted R1 had behaviors. CMA C did not verbally report R1 had behaviors even though CMA would call her on the phone to report other things. R1 was afraid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046087	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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
S3026	Continued From page 5	S3026		

the rest day after the incident on 10/27/23 and was afraid during the weekend. She did not want to get out of bed. When staff entered her apartment, R1 pointed to her cheek and asked if they saw her skin tear. R1 had improved since the incident and did not appear to be afraid anymore.

On 11/06/23 at approximately 04:13 PM Administrative Staff A stated she had never witnessed R1 become aggressive toward staff. Her behavior was being demanding.

On 11/06/23 at 04:40 PM CMA E stated if R1 did not like any staff she would tell them to get out. She can be verbally offensive depending on the day. R1 had not been physically aggressive toward her or others but she had heard other CNA's report that R1 would fight back and argue if she did not like something. CMA E had never witnessed other staff abusing any residents. She been provided Abuse, Neglect, and Exploitation training by the facility and when to report suspicious activity.

The facility's January 2015 "Abuse & Neglect Reporting - Kansas Specific" policy documented "Kansas communities strive to maintain an environment that supports each Resident's right to be free from either the threat or the occurrence of any abusive behavior. Such behavior may include, but is not limited to, abuse (verbal, physical, mental, or sexual), neglect or exploitation as defined below. Each Resident will be treated with respect and dignity. Our team members must maintain ethical and professional behavior. We take all reasonable steps to ensure that team members have been properly screened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046087	A. BUILDING: _____ B. WING _____	C 11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK MEADOWS MEMORY CARE	5951 W 107TH STREET OVERLAND PARK, KS 66207

(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
S3026	Continued From page 6 as required by state regulations to minimize the opportunity for inappropriate behaviors." The administrator failed to protect one resident from abuse when a staff member slapped R1 in the face resulting in a skin tear on her left cheek and R1 became afraid she was going to be hurt again. Jeopardy was removed on 10/27/23 at 01:30 PM when CMA C was suspended and escorted out of the facility, following the facility's investigation CMA C was terminated, and the following additional actions were documented by the facility in the "Abatement Plan" 1) Resident was assessed, including skin check 2) Notification to R1's physician, hospice team, and family/responsible party 3) Abuse, Neglect, and Exploitation (ANE) training was held on 10/12/23 4) Additional retraining/in-service on ANE scheduled for 11/10/23 5) Documentation in EHR in-service on 11/03/23	S3026		