Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046094	A. BUILDING: _____ B. WING _____	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST AT COLLEGE VIEW	13600 WEST 110TH TERRACE LENEXA, KS 66215

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #179421, #179266, #175299, #167056, and #166357 at the above named assisted living facility conducted on 04/17/23 and 04/18/23.	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 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(E) The facility reported a census of 73 residents with six residents included in the sample and two closed record reviews. Based on interview and record review the administrator failed to complete an investigation and report to the department within five working days of an initial report to the department of alleged abuse. Findings included: - Record review for R417 revealed an admission date of 05/31/19 with the following diagnoses: rheumatoid arthritis, hypertension, and paroxysmal atrial fibrillation. The 03/01/23 "Functional Capacity Screen" (FCS) identified 417 required physical assistance with bathing, dressing, and toileting; supervision with walking/mobility; and was marked for falls. The 03/01/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide moderate assistance with bathing, extensive assistance with dressing; one-person physical assistance with toileting; minimal assistance or stand-by assistance as needed with walking/mobility; and falls were not addressed on the "NSA." The 03/15/23 amended "NSA" identified facility staff would provide two-person transfers on a	S3028		

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short-term basis due to R417 wore a knee brace for an acute knee injury.

The 03/30/23 at 07:08 PM nursing "Progress Note" by Administrative Nurse B documented a late entry that R417 reported she had pushed her call light during the overnight shift and requested assistance transferring to her bedside commode. Certified Medication Aide (CMA) C told R417 he could not help at that time, but he could lay down an adult protective brief under her. R417 reported CMA C began to leave the room and R417 asked him to stay until she was done. She then asked him to stand outside her apartment until she was done. After she soiled the adult protective brief, CMA C returned to remove the brief and offered pericare, but R417 told CMA C she would do it herself. Administrative Nurse explained to R417 that CMA C could not help her transfer to the commode because she required two-persons to assist her with transfers.

The 04/02/23 at 08:13 PM nursing "Progress Note" by Administrative Nurse B documented a late entry for 03/29/23. Administrative Nurse B was approached by R417 while in the common area and stated she had become more uncomfortable about "what happened the other night." Administrative Nurse B offered to go to a private area to talk. R417 declined at that time because she had an appointment and would be back by 4:00 PM. At 04:45 PM R417 had not returned from her appointment and Administrative Nurse B left the building for the day.

The 04/04/23 at 10:36 PM nursing "Progress

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Note" by Administrative Nurse B documented a late entry for 03/30/23. The nurse was notified R417 had contacted the police department to file a report. R417 told police she pushed her call light and CMA C arrived at her apartment. R417 asked for assistance to transfer to her bedside commode, but CMA C told her she would need to be changed in bed. While putting an adult protective brief under her, CMA C inappropriately violated her sexually. The police office met with Administrative Nurse B and Administrative Staff A and shared what the resident had reported. Administrative Nurse B and Administrative Staff A met with R417 to obtain her statement.

The 03/31/23 "Investigation Statement" by CMA C and the 03/31/23 "Performance Deficiency Notice" revealed the facility began an investigation the next morning after learning about a sexual abuse allegation and placed CMA C on suspension.

On 04/18/23 at 02:24 R417 stated a staff member (who she did not know, had never seen him before, and could not read his name badge in the darkened room) had been sexually abusive to her which she reported to a day shift aid the following morning on 03/27/23. R417 stated the aid then reported what happened to Administrative Nurse B. On 03/29/23, R417 saw Administrative Nurse B in the front common and yelled her name to finally get her attention. R417 told Administrative Nurse B she was angry because she didn't feel like she was being treated like a priority and being protected by the facility. A friend told her to call police so she did. R417 did not reveal the name of the aid she first reported the incident to on the morning of

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S3028	Continued From page 4 03/27/23. On 04/18/23 at approximately 04:12 PM during findings meeting, Administrative Nurse B stated it was reported on the facility's online "Communication Board" by an unknown staff that R417 was upset her call light wasn't answered timely and an aid wouldn't help her transfer to her bedside commode. R417 approached her in the common area and stated "the more she thought about it, she felt more uncomfortable." Administrative Nurse B offered to go with R417 to a private area to talk, but R417 did not want to be late for her appointment. The first time Administrative Nurse B or Administrative Staff A heard there was an allegation of sexual abuse was the evening of 03/30/23 when R417 called the police. Administrative Staff A called the KDADS complaint hotline within 24 hours on 03/31/23 and left a message. On 04/18/23 at approximately 04:57 PM Administrative Staff A and Administrative Nurse B confirmed they had begun an investigation but had not completed it nor submitted it to the department which was 18 days from date of initial report to the department. The administrator failed to complete an investigation and report to the department within five working days of an initial report of alleged abuse.	S3028		
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	S3101		

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S3101	Continued From page 5 shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 73 residents with six residents included in the sample and two closed record reviews. Based on interview and record review the administrator failed to ensure that each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 417 and R419. Findings included: - Record review for R417 revealed an admission date of 05/31/19 with the following diagnoses: rheumatoid arthritis, hypertension, and paroxysmal atrial fibrillation. The 03/01/23 "Functional Capacity Screen" (FCS) identified 417 required physical assistance with bathing, dressing, and toileting; supervision with walking/mobility; and was marked for falls. The 03/01/23 "Negotiated Service Agreement" (NSA) identified facility staff would provide R417 moderate assistance with bathing, extensive assistance with dressing; one-person physical assistance with toileting; minimal assistance or stand-by assistance as needed with	S3101		

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S3101	Continued From page 6	S3101		

walking/mobility; and falls were not addressed on the "NSA."

The 03/15/23 amended "NSA" identified facility staff would provide two-person transfers on a short-term basis due to R417 wore a knee brace for an acute knee injury.

The 03/01/23 "NSA" and 03/15/23 "NSA" were not signed by the resident or a legal representative.

- Record review for R419 revealed an admission date of 03/05/22 with the following diagnoses: atherosclerotic heart disease, hypertension, and repeated falls.

The 01/16/23 "FCS" identified R419 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, eating; was unable to perform management of medications and treatments; and was frequently incontinent of bladder.

The 01/17/23 "NSA" identified facility would provide R419 one-person physical assistance with bathing, dressing, and walking/mobility; she used a grab bar for toileting; two-person assistance with transfers, set up assistance with eating; facility staff administered medications; oxygen equipment was supplied by an outside provider for treatments; and she wore adult protective briefs for bladder incontinence.

The 01/17/23 "NSA" was not signed by R419 or her legal representative.

On 04/18/23 at 01:49 PM Administrative Nurse B

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S3101	Continued From page 7 confirmed R417 and R's "NSAs" were not signed. The administrator failed to ensure that each individual involved in the development of the "NSA" signed the agreement for R303.	S3101		
S3270 SS=F	26-41-104 (b) Written Emergency Plan (b) Each administrator or operator shall ensure the development of a detailed written emergency management plan to manage potential emergencies and disasters, including the following: (1) Fire; (2) flood; (3) severe weather; (4) tornado; (5) explosion; (6) natural gas leak; (7) lack of electrical or water service; (8) missing residents; and (9) any other potential emergency situations. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(b)(8) The facility reported a census of 73 residents. Based on interview and record review the administrator failed to ensure missing resident was included in the written emergency plan. Findings included: - Review of the facility's emergency management preparedness plan lacked evidence	S3270		

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S3270	Continued From page 8 of a detailed written plan to manage a missing resident emergency. On 04/18/23 at 09:58 AM Administrator A confirmed the emergency management plan lacked all the elements required by the department. The facility's 09/15/21 "Tenant/Resident Missing Persons and Elopement Policy and Procedure" documented "It is the policy of this community to investigate all reports of missing tenants/residents. . . The Executive Director/Operator or Director will notify the state licensing agency in the event of an elopement within 24 hours. . . Elopement drills will be conducted at the community at a minimum of annually." The administrator failed to ensure a plan for a missing resident was included in the written emergency plan.	S3270		