Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105019	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 an abbreviated survey for complaints #186491 and #186077 at the above named facility conducted on 03/14/24.	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)(b) The facility reported a census of 21 residents with two residents included in the sample. Based on interview and record review the operator failed to ensure evidence of documentation the "Functional Capacity Screen" (FCS) for R2 was conducted by an administrator or operator, a licensed social worker, or a licensed nurse; and that a licensed nurse conducted an assessment	S3080		

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

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S3080	Continued From page 1 for R2 when her "FCS" indicated health care services were required. Findings included: - Record review for R2 revealed an admission date of 02/01/23 with a diagnosis of muscle weakness. The 01/26/24 "FCS" identified R2 required physical assistance with management of medications and was unable to perform management of treatments. The 01/26/24 "FCS" lacked a signature to confirm assessment was completed by the administrator or operator, a licensed social worker, or a licensed nurse. On 03/14/24 at approximately 03:21 PM Administrative Staff A and B confirmed R2's "FCS" lacked a signature to confirm it was completed by the administrator or operator, a licensed social worker, or a licensed nurse. The operator failed to ensure evidence of documentation the "FCS" for R2 was conducted by an administrator or operator, a licensed social worker, or a licensed nurse; and that a licensed nurse conducted an assessment for R2 when her "FCS" indicated health care services were required.	S3080		