STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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 are the result of a survey for re-licensure with attached complaints conducted on 6/4/19, 6/5/19 and 6/10/19 at the above named assisted living facility in Overland Park, Kansas.	S 000		
S3080 SS=E	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 (c)(1)(2) The census equaled 43 residents; the sample included 4 residents and 3 closed review residents. Based on interviews and review of records, for 2 sampled residents (#606, 607), the operator failed to ensure designated facility staff conducted a screening to determine each resident's functional capacity on or before admission to the facility.	S3080		

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
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3080	Continued From page 1 Findings included: Record review for resident #606 recorded admission date of 4/8/19 with diagnoses of: diabetes mellitus type 2, hyperlipidemia, dementia, Alzheimer's, hypertension, heart failure and chronic kidney disease. (FCS) Functional Capacity Screen dated 4/30/19 recorded resident required physical assistance with bathing, dressing, toileting/ bladder incontinence and management of medications and treatments. FCS completed 22 days after admission. Interview on 6/5/19 at 5:20pm with administrative nurse #B confirmed resident record lacked FCS on or before admission to facility. Record review for resident #607 recorded admission date of 3/2/18 with diagnoses including: obsessive compulsive disorder, osteoporosis, mild cognitive impairment, encephalopathy, arteriosclerotic heart disease and gastroesophogeal reflux disease. FCS dated 10/1/18 recorded resident independent for all health care services. FCS completed 7 months after admission. Record lacked an admission FCS. Interview on 6/5/19 at 5:35pm with administrative nurse #B confirmed resident record lacked FCS on or before admission to facility. For residents #606 and 607 the operator failed to ensure designated facility staff conducted a	S3080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3080	Continued From page 2 screening to determine each resident's functional capacity on or before admission to the facility.	S3080		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 43 residents. The sample included 4 residents and 3 closed review residents. Based on record review, observation and interview for 1 of 4 residents sampled (#604) the operator failed to ensure that each resident's functional capacity at the time of screening is accurately reflected on that resident's screening form. Findings included: - Record review for resident #604 recorded admission date of 9/11/13 with diagnoses of: anxiety, falls, hypertension, hyperthyroidism, hyperlipidemia, diabetes mellitus type 2, hypokalemia, and Alzheimer's. Functional Capacity Screen (FCS) dated 7/30/18 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility, eating (coded 2/ physical assist) and unable to perform management of medications and	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3082	Continued From page 3 treatments. Observation on 6/5/19 at 11:48am in memory care unit dining room revealed resident in a geri/broda chair (a specialized wheelchair that must be pushed by staff) with a Hoyer lift sling (used to transfer when resident is unable to assist) under him/her being fed by certified staff #I. Interview on 6/5/19 at 4:50pm with administrative nurse #B stated FCS coding was inaccurate, resident is unable to perform any bathing, dressing, toileting, transfers, mobility or eating, and should have been coded as a 3 unable to perform, not a 2 as recorded. For resident #604 the operator failed to ensure that each resident's functional capacity at the time of screening is accurately reflected on that resident's screening form.	S3082		
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 43 residents. The sample included 4 residents and 3 closed review residents. Based on record review and	S3090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3090	Continued From page 4 interview for 1 sampled resident (#606) the operator failed to ensure the development of an initial negotiated service agreement at admission. Findings included: Record review for resident #606 recorded admission date of 4/8/19 with diagnoses of: diabetes mellitus type 2, hyperlipidemia, dementia, Alzheimer's, hypertension, heart failure and chronic kidney disease. (FCS) Functional Capacity Screen dated 4/30/19 recorded resident required physical assistance with bathing, dressing, toileting/ bladder incontinence and management of medications and treatments. (NSA/HCSP) negotiated service agreement/ health care service plan dated 5/6/19 recorded resident to be assisted with bathing and dressing, resident is independent with toileting and continent of bowel and bladder, and licensed/ trained unlicensed staff to assist with and/or administer medications. NSA/HCSP developed 28 days after admission. Interview on 6/5/19 at 5:20pm with administrative nurse #B confirmed resident record lacked NSA on or before admission to facility. For resident #606 the operator failed to ensure the development of an initial negotiated service agreement at admission.	S3090		
S3101 SS=D	26-41-202 (h) NSA Signatures	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3101	Continued From page 5 (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator 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: The facility reported a census of 43 residents. The sample included 4 residents and 3 closed review residents. Based on record review and interview for 1 resident (#606) the operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement. Findings included: The facility reported a census of 43 residents. The sample included 4 residents and 3 closed review residents. Based on record review and interview for 1 sampled resident (#606) the operator failed to ensure the development of an initial negotiated service agreement at admission. Findings included: Record review for resident #606 recorded admission date of 4/8/19 with diagnoses of: diabetes mellitus type 2, hyperlipidemia, dementia, Alzheimer's, hypertension, heart failure and chronic kidney disease. (FCS) Functional Capacity Screen dated 4/30/19	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3101	Continued From page 6 recorded resident required physical assistance with bathing, dressing, toileting/ bladder incontinence and management of medications and treatments. (NSA/HCSP) negotiated service agreement/ health care service plan dated 5/6/19 recorded resident to be assisted with bathing and dressing, resident is independent with toileting and continent of bowel and bladder, and licensed/ trained unlicensed staff to assist with and/or administer medications. NSA lacked signatures of the individuals involved in development of the agreement. Interview on 6/4/19 at 5:10pm with operator #A stated admission paperwork was completed with resident's [child] and [spouse] participated in NSA. Interview on 6/5/19 at 5:20pm with administrative nurse #B confirmed NSA lacked signatures. For resident #606, the operator failed to ensure the development of an initial negotiated service agreement at admission.	S3101		
S3130 SS=D	26-41-203 (d) Special Care Services (d) Special care. Any administrator or operator of an assisted living facility or residential health care facility may choose to serve residents who do not exceed the facility ' s admission and retention criteria and who have special needs in a special care section of the facility or the entire facility, if the administrator or operator ensures that all of the following conditions are met: (1) Written policies and procedures are	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3130	Continued From page 7 developed and are implemented for the operation of the special care section or facility. (2) Admission and discharge criteria are in effect that identify the diagnosis, behavior, or specific clinical needs of the residents to be served. The medical diagnosis, medical care provider ' s progress notes, or both shall justify admission to the special care section or the facility. (3) A written order from a medical care provider is obtained for admission. (4) The functional capacity screening indicates that the resident would benefit from the services and programs offered by the special care section or facility. (5) Before the resident ' s admission to the special care section or facility, the resident or resident's legal representative is informed, in writing, of the available services and programs that are specific to the needs of the resident. (6) Direct care staff are present in the special care section or facility at all times. (7) Before assignment to the special care section or facility, each staff member is provided with a training program related to specific needs of the residents to be served, and evidence of completion of the training is maintained in the employee's personnel records. (8) Living, dining, activity, and recreational areas are provided within the special care section, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility. (9) The control of exits in the special care section is the least restrictive possible for the residents in that section.	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3130	Continued From page 8 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-203 (d)(3) The facility reported a census of 43 residents. The sample included 4 residents and 3 closed chart residents. Based on record review, observation and interview for 1 (#605) sampled resident, the operator failed to ensure the resident's record contained a written physician's order for admission to a special care services (memory) unit. Findings included: - Record review for resident #605 recorded admission date of 10/1/18 with diagnoses of: dementia, depression and hypertension. Functional Capacity Screen (FCS) dated 10/9/18 recorded resident unable to perform management of medications and treatments. Negotiated Service Agreement and Health Care Service Plan (NSA/HCSP) dated 10/9/18 recorded: provide assistance with administration of medications as needed. Observation on 6/5/19 at 11:48pm revealed resident eating lunch with spouse in the locked memory care unit dining room and on 6/5/19 at 3:32pm in resident and spouses room on the memory care unit, revealed resident sleeping on the couch. Physician's admission orders recorded "Admit to [facility]"	S3130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3130	Continued From page 9 Interview on 6/5/19 at 5:10pm with administrative nurse #B confirmed resident record lacked an admission order for the specialized (memory care) locked unit. For resident #605, the operator failed to ensure the resident's record contained a written physician's order for admission to a special care services (memory) unit.	S3130		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 43 residents. The sample included 4 residents and 3 closed review residents. Based on record review, observation and interview for 3 (#604, 605, 606) sampled residents requiring health care services, the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3155	Continued From page 10	S3155		

negotiated service agreement.

Findings included:

- Record review for resident #604 recorded admission date of 9/11/13 with diagnoses of: anxiety, falls, hypertension, hyperthyroidism, hyperlipidemia, diabetes mellitus type 2, hypokalemia, and Alzheimer's.

Functional Capacity Screen (FCS) dated 7/30/18 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility, eating and unable to perform management of medications and treatments.

Negotiated service agreement/ health care service plan (NSA/HCSP) dated 7/30/18 recorded staff to provide physical assist with bathing, dressing, toileting, transfer, walk/mobility, eating and unable to perform management of medications and treatments.

Observation on 6/5/19 at 12:00pm in resident's room revealed a winged air mattress on resident's bed and a fall mat folded up by the window.

HCSP lacked entries for resident use of a winged air mattress and fall mat.

Interview on 6/5/19 at 4:50pm with administrative nurse #B confirmed resident used a winged air mattress and a fall mat and HCSP lacked entries for these assistive devices.

- Record review for resident #605 recorded admission date of 10/1/18 with diagnoses of: dementia, depression and hypertension.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3155	Continued From page 11 Functional Capacity Screen (FCS) dated 10/9/18 recorded resident unable to perform management of medications and treatments. Negotiated Service Agreement and Health Care Service Plan (NSA/HCSP) dated 10/9/18 recorded: provide assistance with administration of medications as needed. HCSP lacked provider of the services for medication and treatment management. Interview on 6/5/19 at 5:10pm with administrative nurse #B confirmed HCSP lacked the name of provider of medication/treatment management, stated staff give all medications as resident is unable to perform medication and treatment management. Record review for resident #606 recorded admission date of 4/8/19 with diagnoses of: diabetes mellitus type 2, hyperlipidemia, dementia, Alzheimer's, hypertension, heart failure and chronic kidney disease. FCS dated 4/30/19 recorded resident required physical assistance with bathing, dressing, toileting/ bladder incontinence and management of medications and treatments. NSA/HCSP dated 5/6/19 recorded resident to be assisted with bathing and dressing, resident is independent with toileting and continent of bowel and bladder, and licensed/ trained unlicensed staff to assist with and/or administer medications. Nurses notes recorded resident fall on 6/3/19. HCSP lacked entries for assistance with toileting/ bladder incontinence and fall interventions.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3155	Continued From page 12 For residents #604, 605, 606 who required health care services, the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 43 residents. The sample included 4 residents and 3 closed review residents. Based on record review and interview, for 2 sampled residents (#605, 606), the operator failed to ensure the negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. Findings included:	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3165	Continued From page 13 - Record review for resident #605 recorded admission date of 10/1/18 with diagnoses of: dementia, depression and hypertension. Functional Capacity Screen (FCS) dated 10/9/18 recorded resident unable to perform management of medications and treatments. Negotiated Service Agreement and Health Care Service Plan (NSA/HCSP) dated 10/9/18 recorded: provide assistance with administration of medications as needed. "[licensed nurse #H] and other licensed nurse designee are responsible for the implementation and supervision of this service plan." Resident roster identified resident as receiving medication administration assistance from facility. NSA lacked specific (1) nurse responsible for the HCSP. Record review for resident #606 recorded admission date of 4/8/19 with diagnoses of: diabetes mellitus type 2, hyperlipidemia, dementia, Alzheimer's, hypertension, heart failure and chronic kidney disease. FCS dated 4/30/19 recorded resident required assistance with bathing, dressing, toileting and management of medications and treatments. NSA/HCSP dated 5/6/19 recorded resident to be assisted with bathing and dressing, resident is independent with toileting, and licensed/ trained unlicensed staff to assist with and/or administer medications. NSA lacked the name of the licensed nurse responsible for the health care service plan.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3165	Continued From page 14 Interviews on 6/5/19 at 5:10pm and 5:20pm with administrative nurse #B confirmed NSA lacked the name of the licensed nurse responsible (1 nurse) for HCSP for residents #605 and 606. For residents #605 and 606 who required health care services, the operator failed to ensure the negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan.	S3165		
S3211 SS=F	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 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 facility reported a census of 43 residents. The sample included 4 residents and 3 closed	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3211	Continued From page 15	S3211		

review residents. The resident roster identified 38 residents as receiving medication management. Based on observations and interviews for all residents, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on packages of over-the-counter medications and used stock medications for residents.

Findings included:

- Observation on 6/4/19 from 10:55am to 12:10pm during facility tour of medication carts, locked carts contained stock OTC medications (over the counter) labeled with resident room numbers (#) including:

Medication cart for 1st and 2nd floor with certified staff #D:

First drawer: Soothe XP (lubricant) eye drops 0.5 ounces (oz), room #, plus a first name/last initial,
2nd drawer: Osteo Biflex with vitamin D (supplement), 220 tablets,
4th drawer: members mark brand Famotidine (antacid) 20 milligrams (mg) 100 tablets, 2 bottles.
Equate brand Ranitidine (antacid) 150 mg, 65 tablets, Plus 2 more OTC's labeled with only room numbers.

4th drawer right side: Members mark Acetaminophen (pain/fever) 500mg, 500 capsules, Plus 2 more OTCs with only room numbers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046048	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE	9201 FOSTER STREET OVERLAND PARK, KS 66212

(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
S3211	Continued From page 16 3rd drawer right side: 18 additional OTCs labeled only with room numbers. Medication cart for 2nd and 3rd PRN (as needed), with licensed nurse # G: Equate brand Loperamide HCL (diarrhea) 2mg, Plus 10 more OTCs. Tylenol 325mg 100 tablets, no room number, when asked licensed nurse #G stated, "That's house stock" and wrote "stock" on the bottle. Medication cart for 3rd floor: with certified staff #E and #F: 13 OTCs labeled with only room numbers. Medication cart for 1st and 2nd floor float: 6 OTC's labeled with only room numbers. Nurse's treatment cart with administrative nurse #B: Neosporin ointment (antibiotic) 1 oz. expiration date of 5/19 (expired), Sun mark brand triple antibiotic cream 1oz (no name or #) and Protective ointment 2.47 oz, (no name or #) Interview on 6/4/19 at 12:10pm with administrative nurse #B confirmed OTCs lacked full resident names. He/she stated the facility does not have stock OTCs. For all residents of the facility, the operator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the resident on packages of over-the-counter medications and used stock medications for residents.	S3211		