

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 7/9/19, 7/10/19, 7/11/19 7/15/19 and 7/16/19 at the above named assisted living facility in Overland Park, Kansas.	S 000		
S3028 SS=E	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

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (3) The facility reported a census of 91 residents. The sample included 6 residents and 3 closed review residents. Based on record review and interview for 1 sampled resident (#710) and 1 closed review resident (#717) the operator failed to ensure that for allegations of abuse and neglect were reported to the department within 24 hours, an investigation was started of the violation and the department's complaint investigation reports were completed and submitted to the department within five working days of the initial report. Findings included: - Record review for resident #710 recorded admission date of 2/28/18 with diagnoses of: metabolic encephalopathy, cognitive communication deficit,, difficulty walking, hypothyroidism, diabetes mellitus type 2, hyperlipidemia, dementia, depression and anxiety. Functional Capacity Screen (FCS): Record lacked a FCS. Negotiated service agreement/ Health care service plan (NSA/HCSP) dated 6/21/19 recorded resident required physical assistance with: bathing, dressing, toileting, transfers (2 assist), walk/mobility, medications and treatments and has a history of falls. (prior NSA/HCSP not on record). "Charting notes" recorded:	S3028		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3028	Continued From page 2 6/16/19 7:08am: "Resident found lying on the floor on his/her back this morning around 6:05am in his/her bathroom Resident transported to ER (emergency room) by ambulance" 6/16/19 11:34am: Received a call from Registered nurse (RN) at [hospital] stating that resident has fractured his/her left hip and was getting admitted." Interview on 7/11/19 at 10:10am with operator #A and licensed nurse #B, stated facility records lacked an investigation of the fall and lacked a report to the department of the unwitnessed fall with injury. Record review for resident #717 recorded admission date of 5/31/19 with diagnoses including: fracture of right femur, history of falls, osteoporosis, osteoarthritis, hyperlipidemia, vitamin B deficiency, anemia, gastroesophageal reflux disease and anxiety. FCS dated 6/16/18 recorded resident required physical assistance with bathing, dressing, toileting, transfer (walking/mobility: blank) and unable to perform management of medications and treatments. NSA/H CSP dated 6/16/18 recorded staff to assist resident with bathing, dressing, toileting, transfer, management of medications and treatments. Resident independent with mobility. Charting notes for 9/29/18 at 12:37pm recorded: "Nurse was called to third floor. Upon my arrival, the CNAs (certified nurse aides) and CMA (certified medication aide) were assisting resident	S3028		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3028	Continued From page 3 out of the dining room. The resident stated he/she had been kicked by a peer. Upon examination resident had two skin tears, one on his/her left lower leg measuring 7 centimeters (cm) long by 5 cm wide. On his/ her right lower leg measure 3m long by 1.5 cm wide He/she was extremely upset at the other resident. Completed incident report" Charting notes for 12/3/18 at 1:47am, recorded the following: "[resident #717] got sent out to hospital due to another resident possibly kicking him/her. The nurse at the hospital said they did x-rays, but they all came back negative. He/she told me they would be bringing him /her back to the facility" Signed by certified staff #C After visit summary dated 12/2/18 recorded: "Chest wall contusion: Reason for visit: Assault victim". Interview on 7/11/19 at 1:10pm with operator #A and licensed nurse #B stated facility lacked record of investigations/ reports to department for either resident to resident incident. For residents #710 and #717 the operator failed to ensure that for allegations of abuse and neglect were reported to the department within 24 hours, an investigation was started of the violation and the department's complaint investigation reports were completed and submitted to the department within five working days of the initial report.	S3028		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to	S3080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 4 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) The census equaled 91 residents; the sample included 6 residents and 3 closed chart review residents. Based on interviews and review of records, for 2 sampled residents (#709, 710) and 2 closed chart review residents (715, 716), 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. - Record review for resident #709 recorded admission date of 1/8/19 with diagnoses of: Coronary artery disease, Congestive heart failure, chronic kidney disease, dementia, depression, hyperlipidemia, hypertension and osteoarthritis. Functional Capacity Screen (FCS) dated 4/16/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform	S3080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 5 management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/H CSP) dated 4/15/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. Record lacked an admission FCS. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed record lacked an admission FCS. Record review for resident #710 recorded admission date of 2/28/18 with diagnoses of: metabolic encephalopathy, cognitive communication deficit,, difficulty walking, hypothyroidism, diabetes mellitus type 2, hyperlipidemia, dementia, depression and anxiety. Functional Capacity Screen (FCS): Record lacked a FCS. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed record lacked an any FCS. Record review for resident # 715 recorded admission date of 8/31/18 with diagnoses including: atrial fibrillation, anticoagulant therapy with falls, hypertension, hyperlipidemia, congestive heart failure and depression. Record lacked a FCS and NSA. Interview on 9/11/19 at 10:10am with licensed nurse #B confirmed record lacked a FCS and NSA.	S3080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 6 Record review for resident #716 recorded admission date of 2/2/18 with diagnoses of vascular dementia, history of CVA (cerebral-vascular accident), hypertension, hyperlipidemia, diabetes mellitus type 2, osteoarthritis, hypothyroidism, coronary artery disease and edema. Record lacked a FCS and NSA. Interview on 9/11/19 at 10:10am with licensed nurse #B confirmed record lacked a FCS and NSA. For residents #709, 710, 715, 716 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		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3085	Continued From page 7 (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a) The facility census equaled 91 the sample included 6 residents and 3 closed review residents. Based on record review and interview for 6 residents (#709, 710, 711, 712, 713, 714) the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, is done in collaboration with the resident or the resident's legal representative and contained a description of the services the resident will receive, identify the provider of each service and identify each party responsible for payment if outside resources provide a service. Findings included: - Record review for resident #709 recorded admission date of 1/8/19 with diagnoses of: Coronary artery disease, Congestive heart failure, chronic kidney disease, dementia, depression, hyperlipidemia, hypertension and osteoarthritis. Functional Capacity Screen (FCS) dated 4/16/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 4/15/19 recorded staff to provide physical assistance with	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3085	Continued From page 8 bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. Charting notes 4/15/19 4:55pm recorded: "Resident returned to community via family personal transport from [hospital] Rehab care evaluation and treatment referral sent ..." signed by licensed nurse #B. NSA lacked entry for use of outside provider services. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed resident received outside services for PT/OT (physical therapy/occupational therapy) and NSA lacked entry for use of outside provider services. Record review for resident #710 recorded admission date of 2/28/18 with diagnoses of: metabolic encephalopathy, cognitive communication deficit, difficulty walking, hypothyroidism, diabetes mellitus type 2, hyperlipidemia, dementia, depression and anxiety. Functional Capacity Screen (FCS): Record lacked a FCS. Negotiated service agreement/ Health care service plan (NSA/H CSP) dated 6/21/19 recorded resident required physical assistance with: bathing, dressing, toileting, transfers (2 assist), walk/mobility, medications and treatments and has a history of falls. (prior NSA/H CSP not on record). Resident record revealed PT/OT notes for 6/24/19 to 7/10/19.	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3085	Continued From page 9 NSA lacked entry for use of outside provider services. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed resident received outside services for PT/OT and NSA lacked entry for use of outside provider services. Record review for resident #711 recorded admission date of 11/26/18 with diagnoses of diabetic neuropathy, gout, pulmonary hypertension, diabetes mellitus complications, diverticulosis of the large intestine, depression, acid regurgitations and left-diastolic heart failure. Record lacked a FCS and NSA/HCSP. A copy of the NSA/HCSP was located in the certified staff care plan book dated 4/7/19. Document was not signed by any participants. It recorded staff to provide physical assistance with bathing, dressing, toileting, walk/mobility, transfers and management of medications and treatments. [company] hospice to provide services. Hospice notes dated 5/31/19, 6/5/19, 6/7/19 and 6/12/19 recorded home health aide assistance with bathing. NSA lacked services provided by the outside provider and party responsible for payment of the services. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed resident received outside services and NSA lacked entry for outside provider services provided and party responsible for payment. He/she confirmed record lacked a FCS and signed NSA/HCSP stating the	S3085			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3085	Continued From page 10 NSA/HCSP was found in the certified staff care plan book. Record review for resident #712 recorded admission date of 5/10/18 with diagnoses including: congestive heart failure (CHF), spinal stenosis, atherosclerotic heart disease, hypothyroidism, diabetes mellitus type 2, hyperlipidemia, B12 deficiency and chronic kidney disease. FCS dated 9/11/18 recorded resident required physical assistance with bathing, dressing, and toileting and is unable to perform management of medications. NSA/HCSP (most recent) dated 6/1/18 recorded staff to assist resident with bathing, dressing, and toileting and is unable to perform management of medications. Hospice nursing assessment dated 5/1/19 recorded admission to Hospice date on 11/13/18 with diagnosis of CHF. NSA lacked entry for use of outside provider services. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed resident received outside services for Hospice and NSA is the most current and lacked entry for use of outside provider services. Record review for resident #713 recorded admission date of 6/5/19 with diagnoses of: heart failure, atrial fibrillation, chronic kidney disease, paralyzed right vocal cord and right diaphragm, dependent personality disorder, lymphedema and depression.	S3085			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3085	Continued From page 11 FCS dated 6/3/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer and was unable to perform management of medications and treatments. NSA/HCSP dated 6/4/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer and management of medications and treatments. Record revealed outside provider notes for OT 6/6/19, PT 6/12/19, 7/1/19 and 7/8/19. NSA lacked entry for use of outside provider services. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed resident received outside services for PT/OT and NSA lacked entry for use of outside provider services. Record review for resident #714 recorded admission date of 2/2/19 with diagnoses of: non-insulin dependent diabetes mellitus, hypertension, chronic kidney disease, history of back trauma/pain, edema, hypothyroidism, systemic lupus erythematosus. FCS dated 3/30/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. NSA/HCSP dated 3/30/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments.	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3085	Continued From page 12 Physical therapy plan of care recorded start of care services on 2/19/19 with end of care date of 5/28/19. NSA lacked entry for use of outside services. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed resident received outside services for PT and NSA lacked entry for use of outside provider services. For 6 residents sampled (#709, 710, 711, 712, 713, 714) the operator failed to ensure the NSA completed for residents who required health care services, is done in collaboration with the resident or the resident's legal representative and contained a description of the services the resident will receive, identify the provider of each service and identify each party responsible for payment if outside resources provide a service.	S3085		
S3090 SS=E	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 91 residents. The sample included 6 residents and 3 closed chart review residents. Based on record review and interview for 1 sampled resident (#709), and	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 13 2 closed review residents (715, 716) the operator failed to ensure the development of an initial negotiated service agreement. Findings included: - Record review for resident #709 recorded admission date of 1/8/19 with diagnoses of: Coronary artery disease, Congestive heart failure, chronic kidney disease, dementia, depression, hyperlipidemia, hypertension and osteoarthritis. Functional Capacity Screen (FCS) dated 4/16/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 4/15/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. Record lacked an admission NSA. Interview on 9/11/19 at 10:10am with licensed nurse #B confirmed record lacked an admission NSA. Record review for resident # 715 recorded admission date of 8/31/18 with diagnoses including: atrial fibrillation, anticoagulant therapy with falls, hypertension, hyperlipidemia, congestive heart failure and depression. Record lacked a FCS and NSA.	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 14 Interview on 9/11/19 at 10:10am with licensed nurse #B confirmed record lacked a FCS and NSA. Record review for resident #716 recorded admission date of 2/2/18 with diagnoses of vascular dementia, history of CVA (cerebral-vascular accident), hypertension, hyperlipidemia, diabetes mellitus type 2, osteoarthritis, hypothyroidism, coronary artery disease and edema. Record lacked a FCS and NSA. Interview on 9/11/19 at 10:10am with licensed nurse #B confirmed record lacked a FCS and NSA. For residents #709, 715, 716 the operator failed to ensure the development of an initial negotiated service agreement.	S3090		
S3110 SS=F	26-41-203 (a) Range of Services (a) Range of services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of the range of services specified in each resident 's negotiated service agreement. The range of services may include the following: (1) Daily meal service based on each resident's needs; (2) health care services based on an assessment by a licensed nurse and in accordance with K.A.R. 26-41-204; (3) housekeeping services essential for the health, comfort, and safety of each resident; (4) medical, dental, and social transportation; (5) planned group and individual activities that	S3110		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3110	Continued From page 15 meet the needs and interests of each resident; and (6) other services necessary to support the health and safety of each resident. This REQUIREMENT is not met as evidenced by: KAR 26-41-203 (a)(6) The facility reported a census of 91 residents. The sample included 6 residents and 3 closed review residents. Based on interview and record review for 1 (710) sampled resident and 6 (#718, 719, 720, 721, 722, 723) non-sampled residents, the operator failed to ensure the provision or coordination of the range of services specified in each resident's negotiated service agreement including other services necessary to support the health and safety of each resident. Findings included: Review of resident call light logs for 6/30/19 recorded call response times of 20 minutes or more for: resident #710: CLA (call light activated) at 1038pm, CLC (call light cleared) at 10:57pm. RT (response time) 22 minutes. resident #718: CLA at 738pm, CLC at 801pm. RT 22 minutes. resident #719: CLA at 339pm, CLC at 426pm. RT 55minutes. resident #719: CLA at 219pm, CLC at 356pm. RT 1 hour 36 minutes.	S3110		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3110	Continued From page 16 resident #720: CLA at 1143am, CLC at 1207pm. RT 23 minutes. resident #720: CLA at 1028am, CLC at 1057pm. RT 29 minutes. resident #721: CLA at 952am, CLC at 1033pm. RT 41 minutes. resident #722: CLA at 701am, CLC at 748am. RT 46 minutes. resident #723: CLA at 453am, CLC at 609am. RT 1 hour 16 minutes. Review of resident council minutes for 3 months 2/6/19, 4/3/19 and 5/20/19 residents complained of long call light response times. Interview on 7/10/19 at 5:35pm with operator #A stated facility does not have a policy on call lights.	S3110		
S3165 SS=F	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 91 residents. The sample included 6 residents and 3 closed review residents. Based on record review and interview, for all residents, 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	S3165		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 17 nurse responsible for the implementation and supervision of the plan as evidenced by review of resident records for residents (#709, 710, 711, 712, 713, 714) who required health care services. Findings included: - Record review for resident #709 recorded admission date of 1/8/19 with diagnoses of: Coronary artery disease, Congestive heart failure, chronic kidney disease, dementia, depression, hyperlipidemia, hypertension and osteoarthritis. Functional Capacity Screen (FCS) dated 4/16/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 4/15/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HCSP. Record review for resident #710 recorded admission date of 2/28/18 with diagnoses of: metabolic encephalopathy, cognitive communication deficit, difficulty walking, hypothyroidism, diabetes mellitus type 2, hyperlipidemia, dementia, depression and anxiety.	S3165		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 18 Functional Capacity Screen (FCS): Record lacked a FCS. Negotiated service agreement/ Health care service plan (NSA/HCSP) dated 6/21/19 recorded resident required physical assistance with: bathing, dressing, toileting, transfers (2 assist), walk/mobility, medications and treatments and has a history of falls. (prior NSA/HCSP not on record). NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HCSP. Record review for resident #711 recorded admission date of 11/26/18 with diagnoses of diabetic neuropathy, gout, pulmonary hypertension, diabetes mellitus complications, diverticulosis of the large intestine, depression, acid regurgitations and left-diastolic heart failure. Record lacked a FCS and NSA/HCSP. A copy of the NSA/HCSP was located in the certified staff care plan book dated 4/7/19. Document was not signed by any participants. It recorded staff to provide physical assistance with bathing, dressing, toileting, walk/mobility, transfers and management of medications and treatments. NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HCSP. Record review for resident #712 recorded admission date of 5/10/18 with diagnoses including: congestive heart failure (CHF), spinal stenosis, atherosclerotic heart disease,	S3165		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 19 hypothyroidism, diabetes mellitus type 2, hyperlipidemia, B12 deficiency and chronic kidney disease. FCS dated 9/11/18 recorded resident required physical assistance with bathing, dressing, and toileting and is unable to perform management of medications. NSA/HCSP (most recent) dated 6/1/18 recorded staff to assist resident with bathing, dressing, and toileting and is unable to perform management of medications. NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HCSP. Record review for resident #713 recorded admission date of 6/5/19 with diagnoses of: heart failure, atrial fibrillation, chronic kidney disease, paralyzed right vocal cord and right diaphragm, dependent personality disorder, lymphedema and depression. FCS dated 6/3/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer and was unable to perform management of medications and treatments. NSA/HCSP dated 6/4/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer and management of medications and treatments. NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HCSP. Record review for resident #714 recorded	S3165		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 20 admission date of 2/2/19 with diagnoses of: non-insulin dependent diabetes mellitus, hypertension, chronic kidney disease, history of back trauma/pain, edema, hypothyroidism, systemic lupus erythematosus. FCS dated 3/30/19 recorded resident required physical assistance with bathing, dressing, toileting, transfer, walk/mobility and is unable to perform management of medications and treatments. NSA/HCSP dated 3/30/19 recorded staff to provide physical assistance with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. NSA lacked the name of the licensed nurse responsible for the implementation and supervision of the HCSP. Interviews on 7/11/19 at 10:10am with operator #A and licensed nurse #B confirmed all resident records lacked the name of the licensed nurse responsible for the implementation and supervision of the HCSP. Licensed nurse #B is currently acting as the nurse responsible as the prior wellness director quit last week. For all residents, 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 as evidenced by review of resident records for residents (#709, 710, 711, 712, 713, 714) who required health care services.	S3165		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3200	Continued From page 21	S3200		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 91 residents. The sample included 6 residents and 3 closed review residents. Based on record review and interview for 1 sampled resident (#710) operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations. Findings included:	S3200 S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3200	Continued From page 22 - Record review for resident #710 recorded admission date of 2/28/18 with diagnoses of: metabolic encephalopathy, cognitive communication deficit,, difficulty walking, hypothyroidism, diabetes mellitus type 2, hyperlipidemia, dementia, depression and anxiety. Functional Capacity Screen (FCS): Record lacked a FCS. Negotiated service agreement/ Health care service plan (NSA/H CSP) dated 6/21/19 recorded resident required physical assistance with: bathing, dressing, toileting, transfers (2 assist), walk/mobility, medications and treatments and has a history of falls. (prior NSA/H CSP not on record). Observation on 7/10/19 at 9:20am in memory care unit dining room revealed resident in a wheelchair wearing TED hose. (Thombo Embolitic Stockings> special stockings for poor circulation of the legs) Interview on 7/11/19 at 1:10pm with licensed nurse #B confirmed resident wears TED hose and record lacked a physician's order and lacked TED hose being placed on and off by staff on the resident's Medication or treatment record. For resident #710, the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations.	S3200		
S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS	S3211		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 23 (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 91 residents. The sample included 6 residents and 3 closed review residents. Based on observations, record review and interviews for 74 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. Findings included: - Observation on 7/9/19 at 10:25am, during facility tour of West 2nd unit medication cart, revealed 8 bottles of over the counter	S3211		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 24 medications (OTC) including the following: Vita fusion Women's multivitamin (supplement) gummies 70 count, a room number no resident name, Nature made Vitamin C 500mg (milligrams) (supplement) 100 count room number on the cap, Aspirin (pain /fever) 81mg count 120, room number on bottle. Plus 5 more OTC's that lacked the residents' full names on the bottles. At 10:57am in the memory care unit medication cart observed the following OTC medications: Geri Care Acetaminophen 500mg (pain/fever) 100 capsules. Certified Staff #G stated OTC acetaminophen was "house stock", Fluticasone Nasal Spray (allergies) 16 gram bottle, 50mcg (micrograms), room number on bottle, CVS pharmacy brand Vitamin C (supplement) 1000 mg 200 count 4/25/19 written on bottle. OTC medications lacked resident's full name. According to the resident roster 74 residents required medication assistance. For 74 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.	S3211		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3261	Continued From page 25 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 91 residents. The sample included 6 residents and 3 closed review residents. Based on record review and interview for 2 closed review residents (#715, 717) the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident # 715 recorded admission date of 8/31/18 with diagnoses including: atrial fibrillation, anticoagulant therapy with falls, hypertension, hyperlipidemia, congestive heart failure and depression. Charting notes recorded last entry on 2/11/19 at 1:00pm "Called by CNA (certified nurse aide) to resident room. Resident complaining of SOA (shortness of air) ..." Facility move-out report recorded resident was discharged from the facility on 2/24/19 to another facility. Record lacked entry for resident discharge. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed record lacked entry for resident discharge. Record review for resident #717 recorded	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3261	Continued From page 26 admission date of 5/31/19 with diagnoses including: fracture of right femur, history of falls, osteoporosis, osteoarthritis, hyperlipidemia, vitamin B deficiency, anemia, gastroesophageal reflux disease and anxiety. Charting notes for 12/3/18 at 1:47am, recorded the following: "[resident #717] got sent out to hospital due to another resident possibly kicking him/her. The nurse at the hospital said they did x-rays, but they all came back negative. He/she told me they would be bringing him /her back to the facility" Signed by certified staff #C After visit summary dated 12/2/18 recorded: "Chest wall contusion: Reason for visit: Assault victim". Hospital emergency room summary dated 12/2/18 recorded the following "RN (registered nurse) called [facility] and spoke with the CNA who was in the dining hall when the incident occurred he/she stated the resident has been complaining of chest pain since yesterday and only called the ambulance because his/her blood pressure was really high." Record lacked documentation of chest pain on 12/1/18 or 12/2/18. Resident record lacked evidence of a nursing assessment at time of incident including vital signs, any injuries to chest area, notification of family of incident/ transfer to hospital. For residents #715 and 717 the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
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 (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 26-4-104(d)(3) The census equaled 91 residents, the sample included 6 residents and 3 closed chart reviews. Based on interviews and review of records, for all residents, the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly review of the facility's emergency management plan with residents. Findings included:	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3280	Continued From page 28 - On 7/9/19 at 1:05pm during review of disaster preparedness records with maintenance supervisor #F, recorded quarterly reviews of the disaster plan were conducted as follows: With residents: on 6/5/19 with 14 residents at resident council meeting, Tornado, fire, flood and active shooter were discussed. With staff: fire drills are conducted monthly with discussions about tornadoes and floods. On 1/31/18 a power outage drill was conducted, on 5/30 19 an all staff review was conducted of the plan. Relias training for staff was conducted online during March 2019, January 2019, September 2018, July 2018 and April 2018 Interview on 7/10/19 at 9:05am with licensed nurse #B confirmed no other resident disaster training was conducted that was not listed in the resident council meetings. For all residents of the facility the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly review of the facility's emergency management plan with residents.	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	S3298			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3298	Continued From page 29 residents, including donated food, shall meet all applicable federal, state, and local laws and 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 facility reported a census of 91 residents. The sample included 6 residents and 3 closed review residents. Based on record review and interview for all residents living in the assisted living facility and receiving meal services, the operator failed to ensure facility staff served food at the proper temperature. Findings included: - On 7/9/19 at 9:20am during facility tour of the kitchen with dietary services director #D requested food temperature monitoring records. Presented were records for "Last week", records lacked food temperature monitoring logs except	S3298		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3298	Continued From page 30 for 1 meal, no date recorded. No food temperature records were available for any dates. Interview on 7/9/19 at 9:20am with dietary services director #D stated the records are "Very sporadic, I can't get them to record it, they temp it." On 7/9/19 at 10:46am in the memory care unit with memory care coordinator #E, stated he/she cannot find the food temperature monitoring logs. Food is brought from the main kitchen and served on the unit from hot wells. The Kansas Department of Agriculture guidelines titled Focus on Food Safety, reads: Cold foods must be maintained at an internal temperature of 41 degrees or below. Hot foods must be maintained at an internal temperature of 135 degrees or higher. For all residents of the facility the operator failed to ensure facility staff served food at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced	S3299		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210			
(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
S3299	Continued From page 31 by: KAR 26-41-206(e) The facility census equaled 91. Based on observation and record review, the operator failed to ensure the facility staff stored all food under safe and sanitary conditions. Findings included: - Observation on 7/9/19 from 9:20am to 9:45am during facility tour of the main kitchen with dietary services director #D revealed the following: In the Lowboy refrigerated unit: 1 open bag of fresh broccoli with mold present, ¼ bag of Sysco brand blue cheese, 2 open butter in original paper wrapper, open not sealed, 16 ounces each ½ a ham in plastic wrap. Items lacked labels for date and contents. In the reach in refrigerator: 2 ground beef packages, 1 pound each, in plastic wrap, 2 chicken breasts in a plastic bag, 3 packages yellow sliced cheese in plastic wrap, 4 packages white sliced cheese in plastic wrap, Sysco brand chicken base ½ full, Turkey approximately 3 pounds each, 2 packages, a box of take out containing season shrimp, a small white bowl of white cheese and one slice of cooked bacon lying in the bottom of the unit. All items lacked contents and date. In the dry storage room: Large bins of flour, sugar, rice and breadcrumbs, all had scoops lying in the product. On the can rack, a large can of black olives and a large can of red kidney beans, cans dented.	S3299			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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
S3299	Continued From page 32 On 7/9/19 at 10:46am in the memory unit kitchenette refrigerator with memory care coordinator #E, observed the following: Gelatin with fruit in a red plastic container, 4 small packages white cheese in plastic wrap, yellow sliced cheese in plastic wrap and cooked ground beef in plastic wrap. All items lacked dated labels. Review of facility policy on food storage recorded the following: "3. Refrigerated items Cover, label and date all food items." "5. Label and date all storage container or bins. Keep free of scoops" For all residents of the facility, the operator failed to ensure the facility staff stored all food under safe and sanitary conditions.	S3299		
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	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2019
NAME OF PROVIDER OR SUPPLIER THE SHERIDAN AT OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66210		
(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 33 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 91 residents. The sample included 6 residents. Based on record review, and interview, for all residents of the facility, the operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - On 7/9/19 at 3:00 pm, during personnel review with facility operator #A, facility records lacked documentation for tuberculosis (TB) symptom screen questionnaire and 1st and 2nd step TB skin for certified staff #H, hire date 4/1/19; and certified staff #J hire date 2/21/19. Review of records for resident #710 admission date of 2/28/19 lacked record of TB symptom screen or TB skin testing. Interview on 7/11/19 at 10:10am with licensed nurse #B confirmed records lacked evidence of TB testing according to guidelines. For all residents of the facility, the operator failed to ensure compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S3310		