STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 Licensure Resurvey at the above named facility in Olathe, Kansas on 3/12/19, 3/13/19, 3/14/19, 3/18/19, 3/19/19, and 3/20/19. Complaints #132608 and #134608 also investigated. Revised 2567 sent to facility 4/1/2019	S 000		
S3028 SS=F	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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)(3)(A)(B)(C)(D)(E)(F) The census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. The sample included three Residents. Based on interviews and reviews of records, for three of three sampled (#185, #187, and #189), the Administrator failed to ensure allegations of potential abuse, neglect and exploitation were reported to the Department within 24 hours, thoroughly investigated to rule out abuse or neglect and written records of each investigation maintained. Findings Included: By review, the facility policy and procedure titled "Abuse and Neglect Mandated Reporting" included the following: "... will ensure that all identified incidents of alleged or suspected abuse/neglect are promptly reported, investigated, and documented." - Review of record revealed #185 admitted to facility 7/03/17 with diagnoses of Parkinson's, advanced dementia, depression, hypertension, diabetes, repeated falls, right knee replacement, muscle weakness, cognitive communication deficit, benign prostatic hypertrophy, and vitamin D and B12 deficiencies. Current functional capacity screen dated 8/15/18 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; supervision with eating, unable to perform medication and treatment management; with short term memory, memory recall and	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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	S3028		

decision making impairments; with falls/unsteadiness, impaired hearing, used a walker, and used a wheelchair.

Current negotiated service agreement dated 8/23/18 included a general statement that staff would assist with ADL's (activities of daily living) as needed or requested by #185 or his/her family. The NSA lacked a description of services to address fall/unsteadiness prevention.

Interdisciplinary Progress Notes of Medical Record:

8/23/18 - 1836 - staff heard a loud noise in Resident's room... found Resident on floor on his/her back in doorway of bathroom and bedroom... stated "was walking this way and went back"...skin tear to right lower extremity...
8/31/18 - 0900 - had a non-injury fall on 8/30/18 at 2030... no complaint of pain or discomfort...
9/07/18 - 0145 - non-injury fall... had just gotten up with therapist into wheelchair... therapist stepped out for moment to speak with staff... fell out onto floor from wheelchair...
9/14/18 - 8:50pm - non-injury fall... denied pain...
9/18/18 - (no time) - per report #185 was found in bathroom floor. walker was beside bed... no injury reported or noted...
9/28/18 - (no time) - Resident was discovered on the floor had a small laceration to the right side of head... range of motion within normal limits... skin assessed no complaint of pain, headache... acetaminophen given, effective will continue to monitor...
(Next entry) 9/19/18 - 10:20am - Resident arrived back at 0110 from emergency room via family member's vehicle. 4 stitches to right side of head...
10/04/18 - 1928 - yelling out "somebody there?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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	S3028		

staff went to room and Resident was on the floor stated I fell out of this bed... no pain or discomfort...
11/29/18 - 1045 - found by staff on floor next to bed... no injury... does not remember how he/she fell...
01/07/19 - 1200 - found on floor by staff in bathroom... not wearing clothes and was next to toilet... stated was weak and fell when attempting to transfer self to toilet no injuries noted... denied hitting head or having pain...
01/09/19 - 1550 - was getting out of bed and slid to floor did not wait for help got self up... no injuries...

The medical record documented additional falls on 6/28/18, 6/27/18, 6/15/18, 6/12/18, 6/11/18, 5/25/18, 5/17/18, 5/10/18, 4/25/18, 4/14/18, 4/11/18, 4/08/18, 4/03/18, and 4/02/18.
The 02/09/18 FCS in effect at this time assessed #185 in need of supervision only with bathing, dressing, toileting, transfers, mobility; with short term memory, memory recall, and decision making impairments, used a walker and a wheelchair.

The medical record lacked documentation unwitnessed falls, with or without injury, investigated to rule out abuse or neglect.

On 3/14/19 at 5:18pm Administrator #F confirmed the Interdisciplinary Progress Notes failed to document an investigation to rule out abuse and neglect... in regard to the fall on 9/28/18 with resulting sutures to head, Administrator #F stated I don't have anything else... we did not report it that I remember...

For Resident #185, the Administrator failed to investigate and report potential allegations of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 4	S3028		

abuse or neglect related to unwitnessed falls or injuries by a cognitively impaired Resident, assessed as requiring physical assistance with activities of daily living.

- Review of record revealed #187 admitted to facility 3/24/15 with diagnoses of cardiomegaly, non toxic multi-nodular goiter, hypertension, gastroesophageal reflux disease, diabetes, magnesium metabolism disorder, hyperlipidemia, arthritis, peroneal nerve injury, and hypercalcemia.

Current functional capacity screen (FCS) dated 6/11/18 assessed #187 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; independent with eating, unable to perform management of medications and treatments, with bladder incontinence; with falls/unsteadiness, used a walker, wheelchair, and motorized wheelchair.
The prior 5/22/17 FCS assessed #187 in need of physical assistance with bathing, dressing, toileting, and transfers, used a walker and wheelchair.

Current 6/14/18 NSA (negotiated service agreement) included a statement that failed to specify what services #185 to receive "staff will assist #187 with ADL's (activities of daily living) as requested or needed. #187 is able to push his/her pendant for assistance."
The NSA lacked a description of services to address fall prevention.

Interdisciplinary Progress Notes of Medical Record:
01/15/19 - 1933 - witnessed fall... certified nurse aide was trying to help Resident to chair and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 5 Resident was not far enough back and slid down chair onto the floor... no injury... unable to get up... 911 called to assist Resident up... 12/18/18 - 1033 - found on floor by staff in response to call light... slipped out of walker seat... stated pants are slick... no injury... 911 called to assist Resident up... 12/11/18 - 2000 - had a witnessed fall... was going to the bathroom and was in a hurry and lost balance... staff was in the room and witnessed the fall... Resident states "thank goodness he/she was here to prevent me and save me from falling hard"... denied injury... 911 called to pick Resident up off the floor... 5/18/18 - 2023 - called to Resident's room... staff stated Resident was transferring to recliner and tripped over her feet and fell... 911 lift assist called and got Resident up... no injuries noted... left with 911 at 4:10am... initially didn't have pain when fell, however was having soreness at 1250 and had Tylenol... unable to bear weight on left leg... 6/14/18 - 1106 - returned from post acute rehabilitation... (no other information regarding fall or resulting injury in the progress notes of record) 3/26/18 - 1507 - pushed call light and staff alerted nurse Resident was on the floor... stated was trying to move scooter back, was using walker, and scooter and walker caused him/her to fall... 01/14/18 - 1218 - found on floor in bathroom... sitting on bottom... was turning around from vanity, sat on walker, slid to floor... no injury... called 911 and they lifted Resident to feet... On 3/14/19 at 3:10pm Administrator #F confirmed #187 assessed in need of physical assistance with transfers... confirmed staff present for some of these... confirmed no other information available as an investigation to rule out abuse or neglect... not aware these reported... for the most part not unwitnessed...	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 6 For Resident #187, the Administrator failed to investigate and report potential allegations of abuse or neglect related to falls or injuries by a Resident assessed as requiring physical assistance with bathing, dressing, toileting, and transfers. - Review of record revealed #189 admitted to facility 8/27/18 with diagnoses of dementia, history of falls, general weakness, hypertension, probable ataxia/aphasia status post cerebrovascular accident, rhabdomyalysis, and hypertension. Current functional capacity screen dated 01/21/19 assessed #189 in need of physical assistance with bathing, dressing, toileting; independent with transfers and mobility; in need of supervision with eating; unable to perform management of medications and treatments; incontinent of bladder; with short term memory, long term memory, decision making, and memory recall impairments; usually understood and usually understands communication; with falls/unsteadiness, used a walker and wheelchair. Current 01/30/19 NSA (negotiated service agreement) included a statement that failed to specify what services #189 to receive "staff will assist #189 with ADL's (activities of daily living) as needed or requested by #189. The NSA lacked a description of services to address fall/unsteadiness prevention. Interdisciplinary Progress Notes of Medical Record: 9/06/18 - 9:40am - found on floor in bedroom doorway, awake, on left side... denies fall...	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 7	S3028		

oriented to self only... lift assist called by facility...
9/06/18 - found sitting on the floor of apartment by home health... no injuries noted...
9/07/18 - 0801 - went to get Resident for breakfast was laying on side by recliner... unable to tell staff anything about fall or tell paramedics what happened... was incontinent and was neither using pendant or verbally calling for help... unable to get up... to emergency room for evaluation...
9/09/18 - 1715 - called to room by family, Resident on floor on left side... pants down to hips... unaware of what happened... family helped to get up into wheelchair...
9/20/18 - 0820 - found on bottom leaning on left side... stated needs to use restroom... doesn't think he/she hit head... 911 called to assist up from floor...
10/04/18 - 1300 - fell out of wheelchair while transferring to walker... no injuries noted...
10/04/18 - 1751 - slid out of wheelchair in dining room... could not state what he/she was doing or what happened... lift assist called to help get Resident up...
11/01/18 - 0710 - found on the floor next to bed... laying on left side... unable to get up... incontinent while on floor... no injuries... 911 called to pick up from floor and transport to ER for evaluation...
11/14/18 - 0730 - found sitting on floor on buttocks beside bed... no injury noted... unable to verbalize what occurred or what he/she was doing... 911 lift required to get up off floor...
12/12/18 - 1645 - found on floor... denied hitting head... when asked what happened stated "playing"... reported as non-injury...
01/04/19 - 0225 - found on floor next to bed... no injury... stated slid out of bed... at 0730 staff helping Resident get up for the day and Resident started to fall so staff lowered him/her to floor, no signs of injury at that time... complained of left leg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 8 pain, unable to walk... to ER... next entry in record 01/28/19 - 1615 - family is moving belongings to memory care room... will return to new room when discharged from rehab on 01/30/19... 01/31/19 - 0930 - skin tear to right arm "fell into doorway" reported by staff... 5cm (centimeters) first area, 4cm second area, and 1cm third area... 02/01/19 - 1007 - found on floor last night on knees unable to get up... transported to ER and returned sometime last night... no injury... unable to tell us why or how he/she fell... 02/18/19 - 1700 - certified medication aide reported non-injury fall in night approximately 4:00am... 911 called to get Resident up... Resident has no recall of incident "I'm sure it was nothing"... no injury noted... On 3/14/19 at 4:00pm Administrator #F stated for an investigation we talk to staff and try to do root cause... should be documented in the nurses' notes (Interdisciplinary Progress Notes)... I don't recall the 02/18/19 one... not recalling the 02/01/19 one either... For Resident #189, the Administrator failed to investigate and report potential allegations of abuse or neglect related to falls or injuries by a Resident assessed as cognitively impaired, with multiple unwitnessed falls, and assessed as requiring physical assistance with bathing, dressing, toileting, and used a walker and a wheel chair.	S3028		
S3085 SS=E	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	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 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 (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 census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. The sample included three Residents. Based on interviews, and reviews of records, for three of three sampled (#185, #187, and #189), the Administrator failed to ensure the negotiated service agreement (NSA) included a description of service the Resident would receive, and identification of each party responsible for payment if outside resources provide a service. Findings included: - Review of record revealed #185 admitted to facility 7/03/17 with diagnoses of Parkinson's, advanced dementia, depression, hypertension, diabetes, repeated falls, right knee replacement, muscle weakness, cognitive communication deficit, benign prostatic hypertrophy, and vitamin	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 D and B12 deficiencies. Current functional capacity screen dated 8/15/18 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; supervision with eating, unable to perform medication and treatment management; with short term memory, memory recall and decision making impairments; with falls/unsteadiness, impaired hearing, used a walker, and used a wheelchair. Current negotiated service agreement dated 8/23/18 included a statement that failed to specify what services #185 to receive "staff will assist #185 with ADL's (activities of daily living) as needed or requested by #185 or his/her family." The NSA lacked a description of services to address fall prevention. In addition the medical record contained orders for PT (physical therapy) on 01/03/19 and 02/01/19. The NSA lacked the service of PT, lacked the name of the company to provide the PT, and lacked the payment source for the PT. - Review of record revealed #187 admitted to facility 3/24/15 with diagnoses of cardiomegaly, non toxic multi-nodular goiter, hypertension, gastroesophageal reflux disease, diabetes, magnesium metabolism disorder, hyperlipidemia, arthritis, peroneal nerve injury, and hypercalcemia. Current functional capacity screen dated 6/11/18 assessed #187 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; independent with eating, unable to perform management of medications and	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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	S3085		

treatments, with bladder incontinence; with falls/unsteadiness, used a walker, wheelchair, and motorized wheelchair.

Current 6/14/18 NSA (negotiated service agreement) included a statement that failed to specify what services #185 to receive "staff will assist #187 with ADL's (activities of daily living) as requested or needed. #187 is able to push his/her pendant for assistance."
The NSA lacked a description of services to address fall prevention.
In addition the medical record contained orders for PT/OT (physical therapy) on 12/20/18 and on 01/31/19.
The NSA lacked the service of PT, lacked the name of the company to provide the PT, and lacked the payment source for the PT.

- Review of record revealed #189 admitted to facility 8/27/18 with diagnoses of dementia, history of falls, general weakness, hypertension, probable ataxia/aphasia status post cerebrovascular accident, rhabdomyalysis, and hypertension.

Current functional capacity screen dated 01/21/19 assessed #189 in need of physical assistance with bathing, dressing, toileting; independent with transfers and mobility; in need of supervision with eating; unable to perform management of medications and treatments; incontinent of bladder; with short term memory, long term memory, decision making, and memory recall impairments; usually understood and usually understands communication; with falls/unsteadiness, used a walker and wheelchair.

Current 01/30/19 NSA (negotiated service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 agreement) included a statement that failed to specify what services #189 to receive "staff will assist #189 with ADL's (activities of daily living) as needed or requested by #189. The NSA lacked a description of services to address fall/unsteadiness prevention. The medical record documented #189 received home health services for wound care 02/04/19 to 02/14/19, and continued on home health for PT (physical therapy) until 02/27/19. These outside services, the name of the outside provider, and the payment source not included on the NSA. On 3/14/19 at 3:10pm, Administrator #F reviewed the NSA's and confirmed the statements referencing ADL's not specific to the services each Resident required... confirmed the outside provider services, name of company, and payment source not on the the NSA. The Administrator failed to ensure the development of an NSA for #185, #187, and #189 which included a description of services the Residents to receive, failed to specify services by an outside provider, the company name of the outside provider of services, and the payment source.	S3085		
S3102 SS=D	26-41-202 (i) Negotiated Service Agreement Service Received (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by:	S3102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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
S3102	Continued From page 13 KAR 26-41-202(i) The census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. For one of three sampled (#187), the Administrator failed to ensure each Resident received services according to the provisions of the negotiated service agreement (NSA). Findings included: - Review of record revealed #187 admitted to facility 3/24/15 with diagnoses of cardiomegaly, non toxic multi-nodular goiter, hypertension, gastroesophageal reflux disease, diabetes, magnesium metabolism disorder, hyperlipidemia, arthritis, peroneal nerve injury, and hypercalcemia. Current functional capacity screen dated 6/11/18 assessed #187 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; independent with eating, unable to perform management of medications and treatments, with bladder incontinence; with falls/unsteadiness, used a walker, wheelchair, and motorized wheelchair. Current 6/14/18 NSA (negotiated service agreement) included a statement "staff will assist #187 with ADL's (activities of daily living) as requested or needed. #187 is able to push his/her pendant for assistance." The NSA documented "Housekeeping: up to 45 minutes of light housekeeping will be provided one time per week on a scheduled basis as part of the monthly fee. Additional housekeeping services are available and are separately obtained and paid for by Resident at established rates."	S3102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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
S3102	Continued From page 14 On 3/14/19 at 1:30pm, in #187's room, observed large amounts of obvious cobwebs and thick dust in window area of room and on lamp table next to couch. Asked #187 if facility staff cleaned his/her apartment. #187 stated they clean it once a week... they don't dust or clean out the refrigerator. On 3/14/19 at 3:30pm Administrator #F confirmed staff cleans the apartments weekly... they dust but they don't pick up knick knacks, etc... the specifics are in the Resident Handbook... #F stated dusting of the window sills would not be excluded. By review of the Resident handbook, noted for entry/living/dining room and for bedroom "vacuum carpet and dust mini blinds." The Administrator failed to ensure #187 received housekeeping services in accordance with the NSA.	S3102		
S3155 SS=G	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.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 15 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. Based on interviews and record reviews, for three of thee sampled with falls in the last 180 days (#189, #187, and #185), the Administrator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address the health care needs of cognitively impaired Residents with identified unsteadiness/fall risks, histories of falls, and repeat occurrences, some with injuries. #185 identified with falls/unsteadiness at admission, experienced 18 falls in five months, experienced an injury to head on 9/28/18, with transport to hospital and stitches; upon return was on floor four times in four months in the absence of revised care interventions to address falls. #189 identified with falls/unsteadiness at admission, experienced 11 falls in four months, and continued falls (one with resulting skin tears) upon returning to facility after rehabilitation in the absence of revised care interventions to address falls #187 identified with history of falls, on floor three times in four months, and continued falls upon returning to facility after rehabilitation in the absence of revised care interventions to address falls Findings included: - Review of record revealed #185 admitted to facility 7/03/17 with diagnoses of Parkinson's, advanced dementia, depression, hypertension, diabetes, repeated falls, right knee replacement,	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 16	S3155		

muscle weakness, cognitive communication deficit, benign prostatic hypertrophy, and vitamin D and B12 deficiencies.

Current functional capacity screen dated 8/15/18 assessed #185 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; supervision with eating, unable to perform medication and treatment management; with short term memory, memory recall and decision making impairments; with falls/unsteadiness, impaired hearing, used a walker, and used a wheelchair.

Current negotiated service agreement dated 8/23/18 included a general statement that staff would assist with ADL's (activities of daily living) as needed or requested by #185 or his/her family. The NSA lacked a description of services to address fall/unsteadiness prevention.
The Resident Service Plan (HSP) documented stand by assistance with transfer and stand by assistance with ambulation with walker; assistance with dressing, bathing, toileting.

Interdisciplinary Progress Notes of Medical Record:

8/23/18 - 1836 - staff heard a loud noise in Resident's room... found Resident on floor on his/her back in doorway of bathroom and bedroom... stated "was walking this way and went back"...skin tear to right lower extremity...
8/31/18 - 0900 - had a non-injury fall on 8/30/18 at 2030... no complaint of pain or discomfort...
9/07/18 - 0145 - non-injury fall... had just gotten up with therapist into wheelchair... therapist stepped out for moment to speak with staff... fell out onto floor from wheelchair...
9/14/18 - 8:50pm - non-injury fall... denied pain...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 17 9/18/18 - (no time) - per report #185 was found in bathroom floor... walker was beside bed... no injury reported or noted... 9/28/18 - (no time) - Resident was discovered on the floor had a small laceration to the right side of head... range of motion within normal limits... skin assessed no complaint of pain, headache... acetaminophen given, effective will continue to monitor... (Next entry) 9/19/18 - 10:20am - Resident arrived back at 0110 from emergency room via family member's vehicle. 4 stitches to right side of head... 10/04/18 - 1928 - yelling out "somebody there?" staff went to room and Resident was on the floor stated I fell out of this bed... no pain or discomfort... 11/29/18 - 1045 - found by staff on floor next to bed... no injury... does not remember how he/she fell... 01/07/19 - 1200 - found on floor by staff in bathroom... not wearing clothes and was next to toilet... stated was weak and fell when attempting to transfer self to toilet no injuries noted... denied hitting head or having pain... 01/09/19 - 1550 - was getting out of bed and slid to floor did not wait for help got self up... no injuries... The medical record documented additional falls on 6/28/18, 6/27/18, 6/15/18, 6/12/18, 6/11/18, 5/25/18, 5/17/18, 5/10/18, 4/25/18, 4/14/18, 4/11/18, 4/08/18, 4/03/18, and 4/02/18. The 02/09/18 FCS in effect at this time assessed #185 in need of supervision only with bathing, dressing, toileting, transfers, mobility; with short term memory, memory recall, and decision making impairments, used a walker and a wheelchair.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 18	S3155		

The NSA and HSP lacked review and revision after the falls, in order to implement new interventions for fall prevention.

On 3/14/19 at 10:25am certified staff #P stated for fall prevention they just check on him/her... the bed is in the lowest position... and the head and feet of the bed raise with a remote... #185 is pretty patient waiting for help...

On 3/14/19 at 5:18pm Administrator #F confirmed the NSA and HSP lacked interventions to address repetitive falls... confirmed #185 fell on 9/28/18 with resulting sutures to head, Administrator #F stated I don't have anything else... we did review or revisit the NSA or HSP.

For Resident #185, the Administrator failed to ensure the licensed nurse provided or coordinately the provision of health care services to address this Resident's identified cognitive impairment, unsteadiness, and risk for falls. Resident #185 was found on the floor on multiple occasions, and experienced a head laceration with stitches required.

- Review of record revealed #189 admitted to facility 8/27/18 with diagnoses of dementia, history of falls, general weakness, hypertension, probable ataxia/aphasia status post cerebrovascular accident, rhabdomyalysis, and hypertension.

Current functional capacity screen dated 01/21/19 assessed #189 in need of physical assistance with bathing, dressing, toileting; independent with transfers and mobility; in need of supervision with eating; unable to perform management of medications and treatments; incontinent of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 19	S3155		

bladder; with short term memory, long term memory, decision making, and memory recall impairments; usually understood and usually understands communication; with falls/unsteadiness, used a walker and wheelchair.

Current 01/30/19 NSA (negotiated service agreement) included a statement that failed to specify what services #189 to receive "staff will assist #189 with ADL's (activities of daily living) as needed or requested by #189.
The NSA lacked a description of services to address fall/unsteadiness prevention.
The Resident Service Plan (HSP) documented assistance with dressing, bathing, toileting and note added on 01/31/19 for bed frame to be removed to make bed lower.

Interdisciplinary Progress Notes of Medical Record:
9/06/18 - 9:40am - found on floor in bedroom doorway, awake, on left side... denies fall... oriented to self only...
9/06/18 - found sitting on the floor of apartment by home health... no injuries noted...
9/07/18 - 0801 - went to get Resident for breakfast was laying on side by recliner... unable to tell staff anything about fall or tell paramedics what happened... was incontinent and was neither using pendant or verbally calling for help... unable to get up...
9/09/18 - 1715 - called to room by family, Resident on floor on left side... pants down to hips... unaware of what happened...
9/20/18 - 0820 - found on bottom leaning on left side... stated needs to use restroom... doesn't think he/she hit head...
10/04/18 - 1300 - fell out of wheelchair while transferring to walker... no injuries noted...
10/04/18 - 1751 - slid out of wheelchair in dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 20 room... could not state what he/she was doing or what happened... 11/01/18 - 0710 - found on the floor next to bed... laying on left side... unable to get up... incontinent while on floor... no injuries... 11/14/18 - 0730 - found sitting on floor on buttocks beside bed... no injury noted... unable to verbalize what occurred or what he/she was doing... 12/12/18 - 1645 - found on floor... denied hitting head... when asked what happened stated "playing"... reported as non-injury... 01/04/19 - 0225 - found on floor next to bed... no injury... stated slid out of bed... at 0730 staff helping Resident get up for the day and Resident started to fall so staff lowered him/her to floor, no signs of injury at that time... complained of left leg pain, unable to walk... to ER... Next entry in record 01/28/19 - 1615 - family is moving belongings to memory care room... will return to new room when discharged from rehab on 01/30/19... 01/31/19 - 0930 - skin tear to right arm "fell into doorway" reported by staff... 5cm (centimeters) first area, 4cm second area, and 1cm third area... 02/01/19 - 1007 - found on floor last night on knees unable to get up... transported to ER and returned sometime last night... no injury... unable to tell us why or how he/she fell... 02/18/19 - 1700 - certified medication aide reported non-injury fall in night approximately 4:00am... 911 called to get Resident up... Resident has no recall of incident "I'm sure it was nothing"... no injury noted... The NSA/HSP's lacked interventions to address Resident's repetitive, unwitnessed falls. The NSA lacked a description of services to include home health services for wound care, and home health for PT (physical therapy).	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 21 The final PT visit documented in Interdisciplinary Progress Notes of 02/21/19 documented: "last day with PT, PT left simple exercises for Resident to continue, will continue to monitor." These exercises and instructions for staff not located on the NSA or in the medical record. On 3/14/19 at 3:10pm Administrator #F stated we do not do PT... as far as cuing or reminding #189 to do the exercised PT left, I will have to ask about that... confirmed nothing on NSA or HSP in regard to ongoing exercises. On 3/14/19 at 10:10am certified staff #P stated to prevent falls we get #189 out of bed on first shift and into the bathroom... we have lowered the bed couple months ago... we just go and check on him/her... we know the people and periodically through the day ask have to use the bathroom... walk beside him/her when using the walker... certified staff #P stated PT is finished for this Resident. On 3/14/19 at 4:00pm Administrator #F stated if we had a root cause or if put intervention into place goes on the HSP... confirmed the NSA and HSP lacked revision and interventions to address repeated falls of a Resident assessed with need for physical assistance by staff... For Resident #189, the Administrator failed to ensure the licensed nurse provided or coordinately the provision of health care services to address this Resident's identified cognitive impairment, unsteadiness, risk for falls, repeated falls, and lack of follow up exercises recommended by PT. Resident #189 was found on the floor on multiple occasions before and after experiencing skin tears to arms, with hospital transfers for evaluation and rehabilitation	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 22 admission in between. - Review of record revealed #187 admitted to facility 3/24/15 with diagnoses of cardiomegaly, non toxic multi-nodular goiter, hypertension, gastroesophageal reflux disease, diabetes, magnesium metabolism disorder, hyperlipidemia, arthritis, peroneal nerve injury, and hypercalcemia. Current functional capacity screen (FCS) dated 6/11/18 assessed #187 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; independent with eating, unable to perform management of medications and treatments, with bladder incontinence; with falls/unsteadiness, used a walker, wheelchair, and motorized wheelchair. The prior 5/22/17 FCS assessed #187 in need of physical assistance with bathing, dressing, toileting, and transfers, used a walker and wheelchair. Current 6/14/18 NSA (negotiated service agreement) included a statement that failed to specify what services #185 to receive "staff will assist #187 with ADL's (activities of daily living) as requested or needed. #187 is able to push his/her pendant for assistance." The NSA lacked a description of services to address fall prevention. The Resident Service Plan (HSP) documented stand by assistance with transfer and ambulation with walker, dressing, bathing, toileting. Interdisciplinary Progress Notes of Medical Record: 01/15/19 - 1933 - witnessed fall... certified nurse aide was trying to help Resident to chair and	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 23	S3155		

Resident was not far enough back and slid down chair onto the floor... no injury... unable to get up... 911 called to assist Resident up...
12/18/18 - 1033 - found on floor by staff in response to call light... slipped out of walker seat... stated pants are slick... no injury... 911 called to assist Resident up...
12/11/18 - 2000 - had a witnessed fall... was going to the bathroom and was in a hurry and lost balance... staff was in the room and witnessed the fall... denied injury... 911 called to pick Resident up off the floor...
5/18/18 - 2023 - called to Resident's room... staff stated Resident was transferring to recliner and tripped over her feet and fell... 911 lift assist called and got Resident up... no injuries noted... left with 911 at 4:10am... initially didn't have pain when fell, however was having soreness at 1250 and had Tylenol... unable to bear weight on left leg... 6/14/18 - 1106 - returned from post acute rehabilitation... (no other information regarding fall or resulting injury in the progress notes of record)
3/26/18 - 1507 - pushed call light and staff alerted nurse Resident was on the floor... stated was trying to move scooter back, was using walker, and scooter and walker caused him/her to fall...
01/14/18 - 1218 - found on floor in bathroom... sitting on bottom... was turning around from vanity, sat on walker, slid to floor... no injury... called 911 and they lifted Resident to feet...

On 3/14/19 at 3:10pm Administrator #F confirmed #187 assessed in need of physical assistance with transfers... confirmed staff present for transfer assistance for some of these and still fell... confirmed the NSA/HSP lacked interventions to address fall prevention for #187.

For Resident #187, the Administrator failed to ensure the licensed nurse provided or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 24 coordinately the provision of health care services to address this Resident's identified unsteadiness, and risk for falls. Resident #187 experienced falls with and without staff present, with hospitalization transfers and rehabilitation in between.	S3155		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(i) The census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. The sample included three Residents. Based on review of record and interview, for one of three sampled (#187) and an unknown number of non-sampled, the Administrator failed to ensure all health care services, including answering call lights, provided by qualified staff in accordance with acceptable standards of practice. Findings included: - By confidential interview on 3/14/19 an individual stated the call lights/pendants are not answered timely... they can ring and ring and ring... sometimes 15 or 20 minutes or more... Resident(s) do not feel secure... sometimes only one staff available at night and Residents have to	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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
S3171	Continued From page 25	S3171		

wait extended periods of time for staff to respond...

On 3/14/19 at 4:30pm Administrator #F stated we do have a call light logging system... the system will show us what time a call bell or pendant was activated and what time the staff answered the call or attended to the Resident's needs.
Administrator #F demonstrated the computer used to observed time lapses between a Resident's call for assistance and staff assistance.
Administrator #F stated the computer not hooked to a printer to run a log for all sampled Residents.
Administrator #F displayed and reviewed the call light activations for one of the three sampled Residents #187, one screen of four activations at a time.
Review of 135 call light activations between 02/27/19 and 3/14/19 revealed:
One to five minutes response - 46
Six to ten minutes response - 32
Eleven to fifteen minutes response - 22
Sixteen to twenty minutes response - 14
Twenty one to thirty minutes response - 7
More than thirty minutes response - 14

The longest time wait time logged in this period was 41 minutes.
The log included seven activations that contained the caption "Response required but not received as of... (with a time recorded)" and another caption "announced 4 to 9 times"

By interview on 3/14/19 at 5:00pm, Administrator #F stated if a Resident complained that their call light was not answered timely, #F would review the computer log, and/or video cameras to verify the length of time lapse... and then he/she would discuss the delays with staff on duty or staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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
S3171	Continued From page 26 observed on the video cameras. On 3/18/19 Administrator #F stated the call light log caption "announced 9 times" means it went through our computer system 9 times. So if no one answers, it will send a 2nd, 3rd, 4th, etc page. This could mean that no one cleared the page or it didn't clear correctly. The staff have a button they match up with the residents button and they have to push it at the same time to "clear" the page. The caption "response required but not received" means if the page goes through 9 times without being "cleared", it sends this message. An online search for "How long should it take to answer a call light? provided the search result - in an article at www.americannursetoday.com which documented the following: "Of course, there are going to be emergency situations where the time it takes to answer a patient's call is going to be longer than the nurse or patient would like. However, on average, the patient should not have to wait longer than three to four minutes at the most to get their call light answered." The facility lacked a policy and procedur on the expectations of staff for call light response and failed to have a system to monitor call light response. The Administrator failed to ensure all health care services for Residents in need of assistance provided by qualified staff in accordance with acceptable standards of practice.	S3171		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 27 (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 census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. The sample included three Residents. The Resident roster identified three Residents with facility managed medications. Based on interview and record review, for three of three sampled (#187 and #189), the Administrator failed to ensure all medications and biological's administered to Residents in accordance with a medical care provider's written orders and in accordance with professional standards of practice. Findings included: - Review of record revealed #187 admitted to	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 28 facility 3/24/15 with diagnoses of cardiomegaly, non toxic multi-nodular goiter, hypertension, gastroesophageal reflux disease, diabetes, magnesium metabolism disorder, hyperlipidemia, arthritis, peroneal nerve injury, and hypercalcemia. Current functional capacity screen dated 6/11/18 assessed #187 unable to perform medication and treatment management. Current negotiated service agreement (NSA) dated 6/14/18 documented facility staff to provide medication and treatment administration, and Resident to self administer insulin. Comparison of the March 2019 medication administration record (MAR) with signed physician orders revealed discrepancies: MAR contained an order for acetaminophen (analgesic) 500mg (milligrams) one tablet every 4 to 6 hours as needed for pain; the medical record lacked a signed physician's order for this medication MAR contained an order for artificial tears eye drops instill one drop in each eye every 2 hours as needed for post injection/dry eyes; the medical record contained orders dated 9/19/18 and 11/28/18 that directed "use as needed." MAR contained an order for loperamide (anti-diarrheal) 1mg/7.5ml (milliliters) liquid by mouth every 6 hours as needed for diarrhea three times a week; the medical record lacked a signed physician's order for this medications On 3/14/19 at 12:38pm, licensed nurse #N confirmed the medical record lacked the signed	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 29 physician's orders for these medications. - Review of record revealed #189 admitted to facility 8/27/18 with diagnoses of dementia, history of falls, general weakness, hypertension, probable ataxia/aphasia status post cerebrovascular accident, rhabdomyalysis, and hypertension. Current functional capacity screen dated 01/21/19 assessed #189 unable to perform medication and treatment management. Current negotiated service agreement (NSA) dated 01/30/19 documented facility staff to provide medication and treatment administration. Comparison of the March 2019 medication administration record (MAR) with signed physician orders revealed a discrepancy: MAR contained an order for Imodium (anti diarrheal) 2mg (milligrams) one tablet PO (by mouth) TID three times daily). The signed physician's order dated 02/15/19 documented "Imodium 4mg 1st dose then 2nd dose 2mg Po TID PRN (as needed). On 3/14/19 at 12:51pm licensed nurse #N confirmed the written order did not match the MAR. On 3/14/19 at 3;10pm, Administrator #F confirmed the medical records lacked orders to match the MARs. The Administrator failed to ensure all medications administered to #187, #189, and #185 in	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 30 accordance with written medical care provider orders, and in accordance with professional standards of practice.	S3200		
S3211 SS=E	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 census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. The sample included three Residents. The Resident roster identified three Residents with facility managed medications. Based on observation and interview, for nine non-sampled (#170, #172, #174, #175, #176, #177, #178, and #173) with over the counter medications, the Administrator failed to ensure a licensed nurse or licensed pharmacist placed the full name of the Resident on each accepted original, unbroken manufacturer's package of over-the-counter	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 31 (OTC) medication for Resident administration. Findings included: - By observation on 3/14/19 from 11:00am to 12:10pm, in review of facility medication carts (three carts) with medication aide #M, the following noted to lack the first and last name of each Resident: Cart for Hall three No name on two tubes of Lidocain and Prilocain Cream #175 - Bottle of Pepto Bismal (stomach upset), no first and last name #177 - Bottle of Tums (antacid) tablets, no first and last name No name on a box of Mucinex Fast Max (expectorant) tablets #175 - Bottle of vitamin B12 (supplement), bottle of Vitamin D3 (supplement) 25mcg (micrograms) capsules, bottle of Super B complex tablets, and Preservision Ared 2 (eye vitamins) tablets, without first and last names Cart for Hall two No name on tube of Estrace (prescription hormone) cream #176 - bottle of Centrum Silver (multi vitamin) tablets, without first and last name No name on open package of Cosopt (glaucoma eye drop)	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 32 No name on open package of Zioptan (glaucoma eye drop) No name on bottle of ibuprofen (pain reliever) tablets No name on bottle of Chlortabs (allergy) 4mg (milligrams) tablets Bottle of Linzess (irritable bowel syndrome) with prescription label torn off #174 - bottle of Aspirin (heart) 81mg tablets, Pepcid (acid reducer) 20mg, without first and last name No name on an open Victoza (diabetes) injection pen #172 - bottle of Miralax (laxative) powder, bottle of Centrum Silver (multivitamin), bottle of Aspirin (heart), bottle of Aleve (pain) 220mg tablets, bottle of Normal Saline spray 0.9%, without first and last name #170 - tube of Neosporin (topical antibiotic) ointment and bottle of Hibiclenz (antiseptic) cleaner with first and last name Cart for Hall one #178 - box of Mucinex DM (expectorant/cough suppressant) tablets, without first and last name Two tubes of Triple antibiotic ointment without first and last name, one of these expired 01/2019 #173 - two bottle of Melatonin (sleep) 1mg (milligram) tablets, acetaminophen (analgesic)	S3211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 33 325mg tablets (also noted to be expired 01/2019), package of Max Health probiotic caplets, Pro Air (bronchodilator) inhaler, without first and last name On 3/14/19 at 5:15pm Administrator confirmed over the counter mediations listed above lacked first and last names and were being replaced until the owner of the medication could be determined and the name placed on the packages. The Administrator failed to ensure the licensed nurse or licensed pharmacist placed the first and last names of Residents on each accepted, original, unbroken manufacturer's package of OTC medication for Resident administration.	S3211		
S3310 SS=E	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 This REQUIREMENT is not met as evidenced by:	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 34 KAR 26-41-207(b)(5-6)(c) The census equalled 34 Assisted Living, 20 Residential Health Care, and four Adult Day Care Residents. The sample included three Residents. The facility identified 73 employees hired since the last Resurvey with five of these reviewed. Based on interview and reviews of records for three of three sampled Residents (#189, #187, and #185), and for five of five employees reviewed (#F and #C), the Administrator failed to ensure the facility's compliance with the Departments' tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. Findings included: - Review of employee records on 3/13/19 at 2:30pm with Administrator #F revealed the following: #189 - admitted to facility 8/27/18; TB symptom screen questionnaire completed 12/05/18 #187 - admitted to facility 3/24/15 - TB symptom questionnaire completed 12/05/18 #185 - admitted to facility 7/03/17 - TB symptom screen completed 12/05/18 and 01/02/18 #A - Certified nurse aide - hired 02/13/19 - no TB symptom questionnaire completed at time of hire #B - Certified medication aide - hired 01/16/19 - no TB symptom questionnaire completed at time of hire #C - Certified medication aide - hired 10/31/18 - no TB symptom questionnaire completed at time	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046059	A. BUILDING: _____ B. WING _____	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LAKE VILLAGE	15325 S LONE ELM RD OLATHE, KS 66061

(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 35 of hire #D - Certified nurse aide - 10/31/18 - no TB symptom questionnaire completed at time of hire #E - Licensed practical nurse - hired 10/17/18 -no TB symptom questionnaire completed at time of hire On 3/13/19 at 2:30pm, Administrator #F stated we do the symptom screens annually but not at time of hire or admission as required. On 3/18/19 Administrator provided the facility policy and procedure for TB testing. This policy and procedure observed to lack the most current (2013) Department suggested guidelines for TB surveillance. The policy and procedure documented "once a conditional offer has been made, the TB test will be administered and documented using the Employee/Candidate Mantoux Questionnaire." The Administrator failed to ensure the facility's compliance with the Department's TB guidelines for adult care homes for employees #A, #B, #C, #D, #E, #F, Residents #189, #187, and #185.	S3310		