

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS The following citations represent the findings of a revisit for correction order 18-191 at the above named assisted living facility conducted on 1-2-19 and 1-3-19.	{S 000}		
S3200 SS=E	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: K.A.R. 26-41-205(d) The facility reported a census of 49 residents. The sample included 3 residents. Based on record review and interview for 2 (#1101, #1102) of 3 sampled residents, the Operator failed to ensure that all medications and biologicals are administered in accordance with a medical care providers written order and professional	S3200		

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: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA			STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 1 standards of practice. Findings included: - Record review for Resident #1101 revealed admission on 12-22-18 with diagnoses Hyperlipidemia, Osteoporosis, Mild Dementia and Hard of Hearing. The Functional Capacity Screening dated 12-21-18 for admission recorded resident required physical assistance with management of medications and treatments. The Negotiated Serviced Agreement/Health Care Service Plan dated 12-24-18 recorded the resident to receive services for medication administration. Review of Medication Administration Record (MAR) for December 2018 revealed Tylenol 650 mg administered by CMA #E on 12-25-18, 12-28-18 and 12-30-18; and CMA #F on 12-28-18 for "pain or elevated temperature" (no temperatures recorded on MAR). Physician order dated 12-24-18 stated: Tylenol 325 mg (milligrams) 2 tablets by mouth every 8 hours as needed. The order lacked parameters for administration of Tylenol. The MAR lacked documentation that medication was administered following an assessment and instruction by a licensed nurse to administer. The record further lacked documentation of an assessment and follow up for effectiveness by a licensed nurse. Further review of the December MAR revealed Macrobid (Nitrofurantoin) 100 mg 1 capsule by mouth twice daily for 7 days. The medication was	S3200			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215			
(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 2 documented as administered once a day at 8:00 am on 12-23-18 and 12-24-18. The record lacked documentation of administration twice daily. The record lacked documentation of a signed physician order sheet for all medications at time of admission and specifically lacked documentation of an order for resident to receive Macrobid, an antibiotic for urinary tract infection. Interview on 1-2-19 at 10:55 am with Administrative Nurse B and Operator confirmed the record lacked documentation of signed medication orders upon admission, an order for the Macrobid, clarification of parameters to administer Tylenol and instruction from a licensed nurse for CMAs to administer PRN Tylenol. For Resident #1101, the Operator failed to ensure all medications and biologicals were administered in accordance with professional standards of practice. - Record review for Resident #1102 revealed admission on 8-17-18 with diagnoses Dementia, Bladder Spasms, Insomnia, and Depression. The Functional Capacity Screen dated 8-2-18 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan dated 8-17-18 recorded services for staff to provide medication management and to monitor for knee and back pain and symptoms of anxiety. Review of the Medication Administration Record	S3200			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 3 (MAR) for December 2018 revealed the record lacked documentation of medication administration as follows: Chewable Aspirin 81 mg (milligrams) for stroke prevention: 12-14-18 and 12-30-18 at 8:00 am. Diclofenac Gel 1% apply 4 grams to affected area four times a day (for pain): 12-1-18 and 12-2-18 at 4:00 pm and 8:00 pm; 12-14-18 and 12-15-18 at 8:00 am and 12:00 pm; 12-30-18 at 8:00 am and 12:00 pm. Duloxetine 30 mg (milligrams) daily for Depression: 12-14-18 at 8:00 am; 12-30-18 at 8:00 am. Ferrous Sulfate 325 mg for iron supplement: 12-14-18 and 12-30-18 at 8:00 am. Fluoxetine 10 mg for Depression: 12-14-18 and 12-30-18 at 8:00 am. Pramipexole 0.25 mg twice a day for dopamine agonist: 12-1-18 and 12-2-18 at 8:00 pm; 12-14-18 and 12-30-18 at 8:00 am. Quetiapine 25 mg at bedtime for insomnia: 12-1-18 and 12-2-18 at 8:00 pm. Tolterodine 4 mg daily for bladder spasms: 12-14-18, 12-15-18 and 12-30-18 at 8:00 am. Trazadone 50 mg take 1/4 tablet twice a day for Insomnia: 12-1-18, 12-2-18 at 4:00 pm; 12-14-18, 12-18-18, 12-30-18 at 8:00 am. Omeprazole 40 mg daily for 4 weeks: 12-1-18, 12-2-18, 12-14-18, 12-18-18, 12-30-18 at 8:00 am. Additionally, the MAR revealed administration of a controlled substance administered on a PRN (as needed) basis by certified staff as follows: Alprazolam 0.25 mg tablet take one orally every 8 hours as needed for anxiety: CMA #C administered on 12-7-18 at 5:00 pm; 12-9-18 at 9:00 pm, 12-11-18 at 6:00 pm, 12-17-18 at 6:00 pm, and 12-31-18 at 6:00 pm. for "resident anxious". CMA #D administered on 12-16-18 at	S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA			STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 4 4:00 pm and 12-29-18 at 5:00 pm for "complaint of anxiety". The record lacked documentation that the controlled medication was administered following an assessment and instruction by a licensed nurse. The record further lacked documentation of an assessment and follow up for effectiveness by a licensed nurse. Interview on 1-2-19 at 11:42 am with Administrative Nurse B and Operator confirmed the record lacked documentation of administration of medication on the above dates and times and further confirmed the record lacked documentation of instruction from a licensed nurse to administer the controlled psychoactive medication including a follow up assessment for effectiveness. For Resident #1102, the Operator failed to ensure all medications and biologicals were administered to the resident in accordance with professional standards of practice.	S3200			
{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 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11)	{S3261}			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 5 The facility reported a census of 49 residents. The sample included 3 residents. Based on record review and interview for 2 (#1101, #1102) of 3 sampled residents, the operator failed to ensure documentation of all incidents, symptoms of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for Resident #1101 revealed admission on 12-22-18 with diagnoses Hyperlipidemia, Osteoporosis, Mild Dementia and Hard of Hearing. The Functional Capacity Screening dated 12-21-18 for admission recorded resident independent with dressing, toileting, transfers, walking/mobility and dating; supervision of bathing; and physical assistance with management of medications and treatments. Usually continent of bladder. No problems with cognition or communication. Current problem/risks included falls/unsteadiness, impaired vision and impaired hearing. The Negotiated Serviced Agreement/Health Care Service Plan dated 12-24-18 recorded the resident to receive services for medication administration, limited assistance with bathing and assistance with activities of daily living as needed. Interview on 1-2-19 at 9:30 am with Administrative Nurse B stated Resident #1101 was currently "in the hospital with pancreatitis" stating the resident had episodes of nausea with vomiting.	{S3261}		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 6 Record review revealed the nurse's notes contained an admit not dated 12-24-18 (resident arrived to facility on 12-22-18 at 3:00 pm) and an additional note dated 12-26-18 regarding adjustment to new environment. The record lacked additional documentation in the nurses's notes. The record lacked documentation of an assessment by a nurse prior to leaving for the hospital including symptoms of illness or date/time resident left the facility to go to the hospital. Interview on 1-2-19 at 10:55 am with Operator and Administrative Nurse B confirmed the record lacked documentation of symptoms of illness and date/time resident was transferred to the hospital. Facility policy for "Hospital Transfer" stated: Purpose: To provide prompt and safe transfer of resident from the facility and to ensure continuity of care through provision of pertinent resident information. Procedure: 1. Explain to resident reason for transfer... 2. The resident may be transferred based on their clinical condition. If life-threatening, call 911. Back up ambulance service should only be called when requested by physician. 3. Notify Operator or Designee and they will notify the family or responsible person or direct you to do so. 4. Arrange transportation and take vitals. 5. Prepare resident for transfer as indicated. Pack necessary personal items. Document on Transfer to Hospital form. 6. Send copy of Physicians Order Sheet, Living Will or Advance Directives and face sheet. 7. Fill out Transfer to Hospital form and put a copy in Administrator/Director of Nursing mailbox.	{S3261}		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 7 8. Secure valuable articles during resident's absence. 9. Straighten up resident's apartment. 10. Lock out resident's apartment. The policy lacked requirement to document a nursing assessment prior to transfer and document date/time resident left the facility. For Resident #1101, the Operator failed to ensure documentation of symptoms of illness, including date/time of transfer from the facility to the hospital. - Record review for Resident #1102 revealed admission on 8-17-18 with diagnoses Dementia, Bladder Spasms, Insomnia, and Depression. The Functional Capacity Screen dated 8-2-18 recorded resident unable to perform management of medications and treatments. Independent with all activities of daily living. Usually continent of bladder. Current problems included impaired vision. The Negotiated Service Agreement/Health Care Service Plan dated 8-17-18 recorded services for staff to assist with bathing, provide reminders and redirection as needed due to moderate cognitive impairment, staff to provide medication management and to monitor for knee and back pain and symptoms of anxiety. Incident/Accident Report dated 11-29-18: "I went in to assist resident to lunch and found him/her on his/her knees in his/her bedroom crawling around the floor. Resident stated that he/she put self on the floor due to being wet. Certified Medication Aide (CMA) assisted resident	{S3261}		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 8 off the floor, management was notified of the incident. (Family member) was notified of the incident and stated (resident) will be going to the doctor on 11-30-18. The record lacked documentation of a follow up nursing assessment. Review of the Medication Administration Record for December 2018 revealed the resident was OOF (out of the facility) from 12-22-18 until 12-27-18. Nurse's Notes: (note: last note written on 10-14-18) 12-31-18 at 4:00 pm: "Per activity staff and certified medication aide, resident has had increased periods of confusion. Has been seen near lobby exit door with jacket on and stating he/she needs a cab. (Family members) notified at this time. Recommending 24 hour care. (Family member) is going to work out something with (another family member) over new years. Will also notify physician." Signed by Administrative Nurse B. The record lacked follow up including a nursing assessment, any actions taken and further lacked documentation of resident leaving the facility for a leave of absence with family from 12-22-18 until 12-27-18. Interview on 1-2-19 at 11:42 am with Administrative Nurse B confirmed the resident left the facility to spend the holiday with family members. Further confirmed the record lacked documentation of date/time resident left (with medications) and returned; and any follow up/assessment of mental status.	{S3261}		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/03/2019
NAME OF PROVIDER OR SUPPLIER GARDEN VILLAS OF LENEXA			STREET ADDRESS, CITY, STATE, ZIP CODE 9705 MONROVIA LENEXA, KS 66215		
(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 9 For Resident #1102, the Operator failed to ensure documentation of an assessment regarding symptoms of increased confusion and date/time of resident going on a leave of absence from the facility.	{S3261}			