

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2016
NAME OF PROVIDER OR SUPPLIER SENIORCARE HOMES NEWPORT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10301 SAGAMORE RD LEAWOOD, KS 66206		
(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 Home Plus Facility in Leawood, Kansas on 12/14/16 and 12/15/16.	S 000		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f) The census equalled five the sample included	S5250		

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: B046042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2016
NAME OF PROVIDER OR SUPPLIER SENIORCARE HOMES NEWPORT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10301 SAGAMORE RD LEAWOOD, KS 66206		
(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
S5250	Continued From page 1 three Residents. Based on interviews and reviews of records, for one of three sampled (#185), the Operator failed to ensure each Resident record contained at least the following: dates of admission, health care service plan, each medical care provider's order if the facility is managing the Resident's medications and treatments. Findings included: - Review of record revealed #185 admitted to facility 01/26/16 with diagnoses of Dementia, Hyperlipidemia, and Anxiety. The current Functional Capacity Screen (FCS) of medical record dated 9/16/16. The prior FCS of record from another facility dated 11/11/15. The medical record lacked an FCS completed at the time of admission to this facility. In further review, the 11/11/15 FCS assessed #185 in need of supervision (1) with bathing and dressing; unable to perform (3) medication and treatment management; with short term memory, memory recall, and decision making impairments; with impaired decision making. The 9/16/16 FCS assessed #185 in need of supervision (1) with bathing and dressing; in need of physical assistance (2) with transfers; unable to perform (3) medication and treatment management; with bladder incontinence, short term memory, memory recall, and decision making impairments; with falls, impaired vision, and wandering. The current Negotiated Service Agreement (NSA) of medical record dated 9/15/16. The medical record lacked an NSA completed at	S5250		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2016
NAME OF PROVIDER OR SUPPLIER SENIORCARE HOMES NEWPORT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10301 SAGAMORE RD LEAWOOD, KS 66206		
(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
S5250	Continued From page 2 the time of admission to this facility. The medical record lacked a Health Service Plan (HSP) completed at the time of admission to this facility. By review, the medical record also lacked an Admission Agreement completed at the time of admission on 01/26/16. By interview on 12/14/16 at 1:35pm, Facility Nurse #F stated I was not the Facility Nurse at this house in January 2016 when admission occurred. On 12/14/16 at 2:00pm, Facility Nurse #F confirmed no FCS, or NSA, or HSP in the medical record. On 12/14/16 at 2:45pm, Facility Nurse #F stated the Facility Nurse in January 2016 was #G... confirmed no admission agreement completed at the time of 01/26/16 admission. On 12/14/16 at 5:01pm, Facility Nurse #F received 01/26/16 from #G and presented to Surveyor, confirmed no NSA or Admission Agreement available. On 12/14/16 at 5:05pm, Facility Nurse #F confirmed move-in check list lacked FCS, NSA, HSP, Admission Agreement... talked with Operator #K... he/she stated when we open facilities our policies and procedures are in accordance with regulations... we would refer to admission policy regulations for our policy and procedures. By interview on 12/14/16 at 5:33pm, Facility Nurse #G stated back in January 2016 we were not aware of the need to do all admission documents when transferring from another company facility... are aware of that now... now follow regulations for policy and procedures doing	S5250		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2016
NAME OF PROVIDER OR SUPPLIER SENIORCARE HOMES NEWPORT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10301 SAGAMORE RD LEAWOOD, KS 66206		
(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
S5250	Continued From page 3 FCS, NSA, and HSP... office staff and Operator take care of the Admission Agreement. The Operator failed to ensure each Resident record contained FCS, NSA, HSP, and Admission Agreement completed at the time of admission to the facility, for #185.	S5250		
S5251 SS=D	26-42-105 (f) (11) Resident Records 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 26-42-105(f)(11) The census equalled five the sample included three Residents. Based on interview and review of records, for one of three sampled (#189), the Operator failed to ensure the documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, a action taken, and results of the action. Findings included: - Review of record revealed #189 admitted to facility 8/25/15 with diagnoses of Frontal temporal dementia, Hypothyroidism, and Urinary incontinence. The current 12/13/16 functional capacity screen	S5251		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2016
NAME OF PROVIDER OR SUPPLIER SENIORCARE HOMES NEWPORT HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 10301 SAGAMORE RD LEAWOOD, KS 66206		
(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
S5251	Continued From page 4 (FCS) assessed #189 in need of physical assistance with bathing, dressing, toileting, transfers, mobility; in need of supervision with eating; unable to perform medication and treatment management; bladder incontinence; impaired memory and decision making; with Falls/unsteadiness, and used a walker. The 12/13/16 negotiated service agreement (NSA) documented staff to provide services to meet these needs. Narrative Notes (NN) of medical record: 4/28/16 - 1120 - description of Resident's ambulation ability and the initiation of a walker for assistance. 6/30/16 - 1230 - 26 lines of page left blank... sticky note on page "Please leave this page - electronic charting on non-injury fall 6/27/16." 8/03/16 - 1730 - description of new medication order... This page of NN incomplete, no further information located. By interview on 12/14/16 at 1:50pm, Facility Nurse #F stated I was not the Facility Nurse at this house in June 2016... I will try to find out if the note is at the office or in the computer... I don't know what non-injury fall the note is referring to... The Operator failed to ensure for #189 the documentation of all incidents, symptoms, the date, time of occurrence, action taken, and results of the action.	S5251		