STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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 are the result of a licensure re-survey with attached complaint conducted at the above named assisted living facility on 11/1/16, 11/2/16, 11/3/16, 11/7/16, 11/8/16 and 11/9/16. Amended 2567 sent to facility on 11/14/16	S 000		
S3015 SS=E	26-41-101 (c) Administration Position Description (c) Administrator and operator position description. Each licensee shall adopt a written position description for the administrator or operator that includes responsibilities for the following: (1) Planning, organizing, and directing the facility; (2) implementing operational policies and procedures for the facility; and(3) authorizing, in writing, a responsible employee who is 18 years old or older to act on the administrator ' s or operator's behalf in the absence of the administrator or operator. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-101(c)(3) The census equaled 42 residents, the sample included 3 residents and one focus review resident. Based on interviews and review of records, operator failed to authorize, in writing, a responsible employee who is 18 years old or older to act on the operator ' s behalf in the absence of the operator. Findings included: - Record review for incident report dated 10/15/16 recorded facility operator #A was away on vacation 10/7/16 to 10/14/16 and returned to	S3015		

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
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3015	Continued From page 1 work on October 15, 2016 for a facility event. Interview on 11/7/16 at 2:20pm with facility operator #A stated office staff #G was in charge during his/her absence. He/she confirmed a letter was not written delegating who was in charge of the facility during his/her absence. Interview on 11/7/16 at 2:55pm with office staff #G, when asked if he/she was in charge of the facility when the operator was absent on vacation, he/she replied " Nope " . The operator failed to authorize, in writing, a responsible employee who is 18 years old or older to act on the operator ' s behalf in the absence of the operator.	S3015		
S3028 SS=J	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.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 2 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (3) The facility reported a census of 42 residents. The sample included 3 residents and 1 focus review resident. Based on record review, observation, and interview for 1 (# 111) sampled resident with the potential to affect all residents of the facility, the operator failed to ensure that allegations of abuse and neglect were reported to the department within 24 hours, that a complete investigation was conducted and that immediate measures were taken to prevent further potential abuse when reports were received that resident #111 had bruises he/she stated were caused by certified staff #D. The failure to take immediate measure to prevent further potential abuse placed all residents in immediate jeopardy for harm and injury. Findings included: - Record review for resident #111 recorded admission date of 5/16/13 with diagnoses of: dementia, high blood pressure and acid reflux.	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 3 Functional Capacity Screen (FCS) dated 6/10/16 recorded resident required assistance with bathing, dressing, and management of medications and treatments. Resident identified with impaired short term memory and memory recall. Negotiated Service Agreement/Health /Care Service Plan (NSA/HCSP) dated 6/10/16 recorded resident to receive staff assistance with bathing, dressing, hygiene after toileting at times, escorts to and from dining room and facility management of medications and treatments. During interview on 11/1/16 at 4:30pm in resident #111 room, when asked if any staff have ever been rough or mean to him/her, resident responded, " Well the aide that helped me the other day, about a week ago, pulled the skin on my arm. " " He/she had on plastic gloves. He/she caught my skin between the glove and my arm. " Resident identified certified staff #D, by name, as the person that caused the injury and stated " he/she does not realize he/she is doing it. " Resident #111 was asked if he/she reported to the nurse, resident responded, " I told (licensed staff #B), he/she (certified staff #D) is too rough. " Observation on 11/1/16 at 4:30pm revealed resident had an oval shaped, light purple bruise approximately 1 ½ inches long by ½ inch wide on the inner aspect of his/her left forearm. Interview on 11/2/16 at 1010am with licensed staff #B, when asked about bruise on resident ' s left forearm, stated " resident has a history of that, I had him/her checked in July, it was on both shins and forearm, he/she (nurse practitioner) did	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 4	S3028		

not see any signs of abuse, he/she saw (resident) in July and October. "

Review of nurses notes dated 7/27/16 at 10:00am, recorded NP (nurse practitioner) and physician here to see resident per this nurse request d/t (due to) discolored bilateral lower extremities. No open skin, no warmth to touch and no c/o (complaints of) pain. Signed by licensed nurse #B

Review of physician progress note dated 7/27/16 (signed by nurse practitioner) recorded: no open lesions. Large bruises B (both) lower legs and arms ....pruritus of skin.

Interview on 11/7/16 at 3:55pm with certified staff #E stated he/she filed a statement in July with licensed nurse #B reporting bruises and skin tear on resident #111.

Review of resident observation/incident report (for resident #111) dated 7/29/2016 recorded observation of a skin tear on resident left upper arm and bruise on right lower arm. Report recorded resident stated certified staff #D had caused the injuries and " handled him/her roughly " and " grabs him/her by the legs and throws him/her into/onto the bed. " Report is signed by certified staff #E. Areas on the resident observation/incident report for documentation of follow up are blank.

Review of resident nurses notes lacked documentation of 7/29/16 skin tear and bruises.

Review of statement from certified staff #C stated he/she believed another employee (certified staff #D) caused the injuries, and a body diagram dated 10/12/16, indicating bruising to the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 5	S3028		

forearm of the resident and the following statement: " resident has fresh bruise on left hand, last bruise was on September 23 on right hand. "

Review of resident #111 nurses notes lacked documentation of any skin issues on 9/23/16 and lacked documentation of assessment and follow up of bruise reported on 10/12 until 10/17/16.

Nurses note at 2:00pm on 10/17/ 16 recorded: " Requested NP (nurse practitioner) see resident for bruising again on left forearm. Bruise covers almost entire forearm. "

Review of physician progress note dated 10/17/16 (signed by nurse practitioner) recorded: skin left arm had 6 cm (centimeter) by 8cm purple to green ecchymosis (a discoloring of the skin resulting from bleeding underneath, typically caused by bruising) .... BLE (bilateral lower extremity) also had yellow to purple bruising, no signs of abuse patterns seen, no picking of skin noted.

Review of staff schedules recorded certified staff #D was scheduled day shift on 10/12/16, 10/13/16, 10/15/16, 10/16/16, 10/18/16, 10/19/16,10/20/16, 10/21/16, 10/24/16,10/25/16, 10/26/16, 10/27/16, 10/29/16, 10/30/16, 11/1/16, 11/2/16, 11/3/16 and 11/4/16. Review of facility timecards for certified staff #D recorded he/she clocked in to work on October 12, 13, 15, 16, 18, 19 (2 shifts), 20, 25, 27, 29, and November 1, 3, 4, and 5, 2016.

Interview on 11/2/16 at 10:30am with licensed nurse #B confirmed certified staff #D continued to work after the allegation of abuse, and is still

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 6 employed as certified staff at the facility. Interview on 11/7/16 at 2:40pm with operator #A confirmed certified staff #D typically works on one floor where 20 residents live. Interview on 11/7/16 at 3:07pm with licensed nurse #B confirmed he/she did not measure the bruised areas, obtained a statement from certified staff #D regarding his/her full day of events in taking care of resident #111 but did not ask specifically about the bruises, failed to obtain a statement from the staff who provided care to the resident on the evening of 10/12/16, did not interview other residents and did not assess other residents certified staff #D provided care for. Facility investigation included: Operator A ' s description of interviews and discussion with staff regarding the incident, record of staff in-service on 10/20/16 (abuse, neglect/ unauthorized photos, infection control/ resident rights and emergency preparedness), Nurse practitioner progress notes for 7/27/16 and 10/17/16, statement from certified staff #D describing the care she provided for resident #111 on 10/12/16 (note: no incidents or injuries reported) , reports of abuse from certified staff #C for 10/12/16 and follow up letters dated 10/24/16 from operator #A to certified staff #C and #E confirming receipt of their reports, and copy of staff schedule for October 9-20th, but lacked nurses notes documenting the date and time the bruises were first noted and measurements of the bruised areas, interviews/statements from all staff assigned to work with resident #111 before and after date of alleged incident(s) to clarify when the bruises first noted, and interventions to ensure resident safety from abuse from alleged employee who continued to work during the time	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 7 of the investigation. Review of department records recorded no report from facility regarding allegation of abuse for 7/29/16 or 10/12/16. Interview on 11/2/16 at 10:30am with facility operator #A confirmed allegations of abuse were not reported to the department as required. Review of facility policy titled " Abuse, neglect and Exploitation Revised September 2016" stated the following: G. Reporting suspected violations: 1. Any suspected, observed or reported violation of the resident safety policy shall be reported immediately to the supervisor and the administrator/designee per facility policy. 2. The supervisor on duty shall immediately report any alleged violations of this resident stafety policy to the administrator/designee or DON/designee. 3. The administrator or designee will be responsible to ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source .... are reported immediately to other officials in accordance with state law including to the state survey and certification agency. H. Procedure for investigation: 1. Administrator/designee on duty will assess the resident (including the size, location, etc. of any injury) and assure proper documentation of the date, time and location of the reported or suspected incident. 2. The supervisory will do everything possible to protect the resident's welfare and safety from harm during the investigations.. . . 6. Any employee suspected of violation of these resident safety policies may be suspended	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 8 pending investigation. . . . The facility received a report of possible abuse 7/29/16 and failed to report, investigate or put measures in place to prevent further abuse. The facility received a second report involving certified staff #D on 10/12/16 and again failed to report, thoroughly investigate, and put measures in place to prevent further abuse. For resident #111 with the potential to affect all residents at the facility, the operator/designee failed to ensure that allegations of abuse and neglect were reported to the department within 24 hours and that a thorough investigation was conducte. The operator/designee further failed to ensure that immediate measures were taken to prevent further potential abuse and neglect after an allegation of abuse was made against an employee. This failures placed residents in immediate jeopardy for harm or injury. The jeopardy was corrected on 11/7/16 when the operator provided a plan which included: - Any employee suspected of violation of these resident safety policies will be suspended upon investigation. Regarding alleged employee (certified staff #D), we will suspend him/her employment immediately from our facility pending another investigation. -A report will be made to the state, moving forward, on any suspicion of abuse, neglect and exploitation (ANE) before investigating - All staff will be re-inserviced on ANE policy within 24 hours or upon returning to work -The administrator/designee will designate appropriate personnel to handle any questions or	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3028	Continued From page 9 calls about the incident - the administrator/designee will interview other residents that have been in the care of accused CMA as well as any nursing, housekeeping, laundry, dietary, activity, maintenance service staff, any visitors or others who may have knowledge of the occurrence or who may have been in the vicinity at the time of the incident(s). The administrator/designee on duty will prepare a written summary of each interview. -We will incorporate " bath skin assessments " as to allow CMA ' s to accurately and timely report any change of skin discoloration regarding resident #111 at least weekly as to alight with his/her days of show assistance from nursing staff. - We will remain in touch with the resident ' s family and physician with any change in condition -For all other circumstances, we will follow company policy and procedure per our ANE policies and procedures. The plan was amended on 11/8/16 to include: - We will incorporate a ' skin assessment ' on all residents who have been in the care or had contact with, in the last two weeks, of certified staff #D within 24 hours,	S3028		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days;	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3081	Continued From page 10 (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1) The facility reported a census of 42 residents. The sample included 3 residents and one focus review resident. Based on record review and interview for 1 focus review resident (#114) the operator failed to ensure designated facility staff conducts a functional capacity screening at least once every 365 days. Findings included: - Record review for resident #114 recorded admission date of 4/1/09 with diagnoses of Guillain-Barre ' , hypertension, asthma and history ruptured rotator cuff. Functional capacity screen (FCS) dated 10/10/15 recorded resident required assistance with bathing, dressing and management of medications and treatments. Record lacked annual functional capacity screen (due 10/9/16). Interview on 11/2/16 at 3:15pm with licensed nurse #B confirmed record lacked annual FCS. For resident # 114 the operator failed to ensure	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3081	Continued From page 11 designated facility staff conducts a functional capacity screening at least once every 365 days.	S3081		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1) The facility reported a census of 42 residents. The sample included 3 residents and one focus review resident. Based on record review and interview for 1 focus review resident (#114) the operator failed to ensure designated facility staff conducts a functional capacity screening at least once every 365 days. Findings included: - Record review for resident #114 recorded admission date of 4/1/09 with diagnoses of	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3092	Continued From page 12 Guillain-Barre ' , hypertension, asthma and history ruptured rotator cuff. Functional capacity screen (FCS) dated 10/10/15 recorded resident required assistance with bathing, dressing and management of medications and treatments. Record lacked annual functional capacity screen (due 10/9/16). Interview on 11/2/16 at 3:15pm with licensed nurse #B confirmed record lacked annual FCS. For resident # 114 the operator failed to ensure designated facility staff conducts a functional capacity screening at least once every 365 days.	S3092		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The census equaled 42 residents, the sample included 3 residents and one focus review resident. Based on interviews and record reviews	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3101	Continued From page 13	S3101		

for one sampled resident (#111), the operator failed to ensure that each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreement.

Findings included:

- Record review for resident #111 recorded admission date of 5/16/13 with diagnoses of: dementia, high blood pressure and acid reflux.

Functional Capacity Screen (FCS) dated 6/10/16 recorded resident required assistance with bathing, dressing, and management of medications and treatments. Resident identified with impaired short term memory and memory recall.

Negotiated Service Agreement/Health /Care Service Plan (NSA/HCSP) dated 6/10/16 recorded resident to receive staff assistance with bathing, dressing, hygiene after toileting at times, escorts to and from dining room and facility management of medications and treatments.

NSA/HCSP dated 6/10/16 was signed by licensed nurse #B and above line for resident signature or legal representative is written: Sarah Rogers/ (licensed nurse #B signature) after talking to (DPOAH) via phone.

Interview on 11/2/16 at 4:00pm with operator #A and licensed nurse #B, confirmed licensed nurse #B signed for resident after talking to DPOAH.

For resident #111, the operator failed to ensure that each individual involved in the development of the Negotiated Service Agreement (NSA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3101	Continued From page 14 signed the agreement.	S3101		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 42 residents. The sample included 3 residents and one focus review resident. Based on record review, observation and interview for 1 (#111) sampled resident and 1 (#114) focus review resident requiring health care services, the operator failed to ensure that a licensed nursed 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. Findings included: - Record review for resident #111 recorded admission date of 5/16/13 with diagnoses of: dementia, high blood pressure and acid reflux.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3155	Continued From page 15 Functional Capacity Screen (FCS) dated 6/10/16 recorded resident required assistance with bathing, dressing, and management of medications and treatments. Resident identified with impaired short term memory and memory recall. Negotiated Service Agreement/Health /Care Service Plan (NSA/HCSP) dated 6/10/16 recorded resident to receive staff assistance with bathing, dressing, hygiene after toileting at times, escorts to and from dining room and facility management of medications and treatments. Observation on 11/1/16 at 4:30pm in resident ' s room revealed a bed cane on the right side of resident ' s full size bed. NSA/HCSP lacked entry for use of a bed cane. Interview on 11/2/16 at 4:00pm with licensed staff #B confirmed resident has and uses a bed cane, and lack of entry on resident ' s NSA/HCSP. Record review for resident #114 recorded admission date of 4/1/09 with diagnoses of Guillain-Barre ' , hypertension, asthma and history ruptured rotator cuff. FCS dated 10/10/15 recorded resident required assistance with bathing, dressing and management of medications and treatments. NSA/HCSP dated 10/10/15 recorded resident to receive staff assistance with bathing, dressing, medication management and resident independently administers antacids and gel.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3155	Continued From page 16 Observation on 11/2/16 at 1:45pm in resident ' s room revealed a bed cane, gold and black in color on right side of full size bed, cane is pushed out approximately 6 inches from bed. NSA/HCSP lacked entry for use of a bed cane. Interview on 11/2/16 at 1:45pm with resident stated he/she ' uses it now and then to turn in bed. " Interview on 11/2/16 at 3:15pm with licensed nurse #B stated resident " never used to " have a bed cane, and confirmed lack of entry on NSA/HCSP. Post-fall assessment dated 9/18/16 at 9:00pm recorded fall with injury (right waist area skin tear) signed by certified staff #F. Resident record contained document dated 2/22/16 " resident is at risk d/t (due to) diagnose and medications. Recorded the following: 1. Encourage resident to call for assistance. 2. Give medications as ordered. 3. Make sure resident wears pendant. 4. Monitor for any changes in behaviors or change in condition. To left side is written the dates 3/20/16 and 9/18/16. (document does not contain a resident ' s name), signed by licensed nurse #B.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3155	Continued From page 17 NSA/HCSP lacked specific interventions for 9/18/16 fall. Interview on 11/2/16 at 3:15pm with licensed nurse #B stated document lists fall interventions for resident #114 for all 3 falls. Confirmed NSA/HCSP lacked specific fall interventions for each fall. For residents #111 and #114 who required health care services, the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3175	Continued From page 18 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (a) The facility reported a census of 42 residents. The sample included 3 residents and one focus review resident. Based on record review, observation and interview for 1 (#114) focus review resident, the operator failed to ensure the licensed nurse performed an assessment that the resident could perform medication self-administration safely and accurately without staff assistance and further failed to ensure the assessment was completed annually. Findings included: - Record review for resident #114 recorded admission date of 4/1/09 with diagnoses of Guillain-Barre ' , hypertension, asthma and history ruptured rotator cuff. Functional Capacity Screen dated 10/10/15 recorded resident required assistance with bathing, dressing and management of medications and treatments. Negotiated agreement/health care service plan dated 10/10/15 recorded resident to receive staff assistance with bathing, dressing, medication management and resident independently administers antacids and gel.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3175	Continued From page 19 Self- administration of medication assessment dated 10/10/15 recorded 10 assessment criteria including: can resident state the name of medication? Can resident correctly state what medication is for? Can resident correctly state common side effect of each medication? All 10 criteria are marked N/A (not applicable). At bottom of form is recorded: CMA ' s (certified medication aides) to administer all medications except OTC (over the counter) antacids and gelnique (prescription topical gel to treat overactive bladder). Interview on 11/2/16 at 1:45pm resident when asked if he/she takes " a gel, called gelnique? " He/she stated, I don ' t know what that is. " Resident stated he/she takes Tums (an antacid), " my tums are in the drawer I take them when I need them. " Resident stated staff administers the rest of her medications and they are locked in a cabinet in his/her room. Interview on 11/2/16 at 3:15pm with licensed nurse #B confirmed resident self- administered antacids; 10/10/15 self- administration assessment is most current and lists all criteria as N/A. Review of facility policy: " medication, self-administration of " , recorded: 1. Before resident is considered for self-administration of medications an assessment will be performed by the community nurse to assure resident is safe managing their own medications. 4. A reassessment of self-administration of medications will be performed by the community nurse annually.	S3175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3175	Continued From page 20 For resident #114, the operator failed to ensure the licensed nurse assessed the resident ' s ability to safely and accurately self administer medications and further failed to ensure that the assessment be completed annually.	S3175		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3248	Continued From page 21 by: KAR 26-41-102 (d) The census equaled 42 the sample included 3 residents and one focus review resident. Based on interviews and reviews of facility records, for 1 licensed staff (#J) and 3 of 4 certified staff (#K, #L and #M) hired, the operator failed to ensure licensed and certified staff, registry and criminal background checks were completed prior to staff working with facility residents Findings included: - Review of personnel records for licensed staff #J (hire date 12/5/15, first work date 12/6/15), recorded documentation of nurse licensure from the Kansas nurse registry dated 12/23/15. Licensure confirmation made 17 days after first day of employment. Review of personnel records for certified staff #K (hire date 5/17/16, first work date 5/18/16), recorded last check for confirmation of certified medication aide licensure from the nurse aide registry on 5/31/16 (13 days after first work date) and criminal background check through health occupations and credentialing on 7/8/16 (51 days after first work date). Review of personnel records for certified staff #L (hire date 4/25/16, first work date 5/1/16) recorded last check for confirmation of certified medication aide licensure from the nurse aide registry on 5/31/16 (30 days after first work date) and criminal background check through health occupations and credentialing on 6/8/16 (38 days after first work date).	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3248	Continued From page 22 Review of personnel records for certified staff #M (hire date 3/2/16, first work date 3/5/16) recorded confirmation of certified medication aide licensure from the nurse aide registry on 3/12/16 (6 days after first work date) and criminal background check through health occupations and credentialing on 3/12/16 (6 days after first work date). Interview on 11/1/16 at 4:00pm with facility operator #A stated criminal background checks are done in batches by the business office manager or him/herself. The operator failed to ensure licensed and certified staff, registry and criminal background checks were completed prior to staff working with facility residents.	S3248		
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) The facility reported a census of 42 residents. The sample included 3 residents and 1 focus review residents. Based on record review and interview for 3 sampled residents (#111,#112 and	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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 23 #113) and one focus review resident (#114), the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #111 recorded admission date of 5/16/13 with diagnoses of: dementia, high blood pressure and acid reflux. Functional Capacity Screen (FCS) dated 6/10/16 recorded resident required assistance with bathing, dressing, and management of medications and treatments. Resident identified with impaired short term memory and memory recall. Negotiated Service Agreement/Health /Care Service Plan (NSA/HCSP) dated 6/10/16 recorded resident to receive staff assistance with bathing, dressing, hygiene after toileting at times, escorts to and from dining room and facility management of medications and treatments. Post-Fall assessment dated 6/19/16 recorded unwitnessed fall at 8:18pm with a " bump on head " and note " went to ER (emergency room) 6/19/16 signed by licensed staff #B on 6/20/16. Nurses notes recorded 6/10/16 at 10:00am regarding the annual NSC (negotiated service	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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 24 contract) and TB (tuberculosis) review and next entry for 7/27/16 at 10:00am regarding physician visit for discolored lower extremities. Record lacked documentation of the fall on 6/19/16 including the date and time of the incident, nurse evaluation after fall, transfer to ER, return from ER, results of ER visit and follow up after the fall. Interview on 11/2/16 at 4pm with licensed nurse #B confirmed resident fall with ER visit and lack of documentation. Resident observation/incident report received from licensed nurse #B, dated 7/29/16, written by certified staff #E, recorded observation of a skin tear and bruises to resident arms and allegation of abuse by another staff member. Nurses notes recorded entries for 7/27/16 signed by licensed nurse #B with the next entry recorded 8/2/16 at 10:00am. Record lacked documentation of the date and time the skin tear and bruises were reported, physical assessment and measurement of bruises to arms and skin tear, notification of primary physician and notification of family. Record review for resident #112 recorded admission date of 1/5/10 with diagnoses of:	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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 25 depressive disorder, hypertension, congestive heart failure, cerebrovascular disease, urinary tract infection and right hemiplegia. FCS dated 11/11/15 recorded resident required assistance with bathing, dressing, toileting and management of medications and treatments. NSA/HCSP dated 11/11/15 recorded resident to receive staff assistance with bathing, dressing, toileting and medication management. Nurses notes dated 4/17/15 at 11:55am recorded resident wants to go to ER ... not feeling well ... Nurses notes dated 4/17/15 at 12:25pm recorded resident transported to ER. Nurses notes dated 5/5/15 at 11:20am recorded resident readmitted ....regular diet.. Record lacked documentation of nursing assessment on readmission following illness, including vital signs. Interview on 11/2/16 at 3:15pm with licensed nurse #B confirmed record lacked readmission assessment. Record review for resident # 113 recorded admission date 10/31/16 with diagnoses of chronic renal disease stage 4, hypertension, congestive heart failure, atrial fibrillation, hyperparathyroidism and hypothyroidism.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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 26 FCS dated 10/31/16 recorded resident required assistance with management of medications and treatments. NSA/HCSP dated 10/31/16 recorded resident to receive full medication management. Nurses notes dated 10/31/16 at 2:45pm recorded resident admitted .... Resident is alert/oriented ... independent with all ADL ' s (activities of daily living) ... Record lacked documentation of assessment at time of admission including vital signs, weight and physical assessment for edema or skin issues. Interview on 11/2/16 at 4:00pm with licensed nurse #B confirmed record lacked admission physical assessment, vital signs, a skin assessment and weight. Record review for resident #114 recorded admission date of 4/1/09 with diagnoses of Guillain-Barre ' , hypertension, asthma and history ruptured rotator cuff. FCS dated 10/10/15 recorded resident required assistance with bathing, dressing and management of medications and treatments.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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 27 NSA/HCSP dated 10/10/15 recorded resident to receive staff assistance with bathing, dressing, medication management and resident independently administers antacids and gel. Post-fall assessment dated 9/18/16 at 9:00pm recorded fall with injury (right waist area skin tear) signed by certified staff #F. Notification of Physician recorded on 9/21/16 at 2:20pm via fax signed by licensed nurse #B. Fax to physician dated 9/21/16 recorded non-injury fall on 9/18/16 but now is complaining of left rib pain. X-ray requested. Nurses notes dated 9/19/16 recorded: " Staff notified this nurse on 9/18/16 at approximately 9:25pm regarding a non- injury fall. " Record lacked documentation of the description of the incident, nurse assessment of resident injury and notification of physician at time of injury. Interview on 11/2/16 at 3:15pm with licensed nurse #B confirmed lack of nurse assessment for injury fall and no notification of physician until 9/21/16 by fax. For residents #111,#112, #113 and #114, the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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 28 and results of the action.	S3261		
S3299 SS=E	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The census equaled 42 residents. The sample included 3 residents and one focus review resident. Based on observation and interview for all residents of the facility who use facility food services, the operator failed to ensure facility staff stored all food under safe and sanitary conditions. Findings included: - On 11/1/16 during facility tour from 11:43am to 1:30pm observed the following: In East hall small serving kitchen (servery) a large plastic scoop lying in ice in ice machine bin. In east hall small serving kitchen (servery) in cabinet, container of brown granulated contents no label, no date, small black cup inside. Red and yellow squeeze bottles with white and black granulated contents, no label, no date. Lyons	S3299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046078	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLAS OF LENEXA	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
S3299	Continued From page 29 brand dessert sauce, caramel 17oz, no date opened. In East hall small snack station, a large plastic scoop lying in ice in ice machine bin. In 2nd small snack kitchen, a large plastic scoop lying under ice in ice machine bin. For all residents of the facility who use facility food services, the operator failed to ensure facility staff stored all food under safe and sanitary conditions.	S3299		