Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089041	A. BUILDING: _____ B. WING _____	09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON PARK ASSISTED LIVING	1021 SW FLEMING COURT TOPEKA, KS 66604

(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 complaints conducted at the above named assisted living facility on 9/21/16, 9/22/16 and 9/23/16.	S 000		
S3171 SS=D	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 facility reported a census of 51 residents. The sample included 3 residents, and one focus review resident. Based on record review and interview for 1(#923) sampled resident, the operator failed to provide health care services to the resident by qualified staff in accordance with acceptable standards of practice. Findings included: - Record review for resident #923 recorded admission date of 6/23/15 with diagnoses including: toxic encephalopathy, muscle wasting and atrophy, symbolic dysfunctions, malformation of coronary vessels, atrial fibrillation and COPD (chronic obstructive pulmonary disease). Functional Capacity Screen dated 7/13/16 recorded resident required assistance with bathing, dressing, toileting, management of medications and treatments and supervision with eating.	S3171		

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
	N089041	A. BUILDING: _____ B. WING _____	09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON PARK ASSISTED LIVING	1021 SW FLEMING COURT TOPEKA, KS 66604

(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 1 Negotiated Service Agreement/Health Care Service Plan dated 7/13/16 recorded resident to receive assistance from staff with: bathing, dressing, toileting and management of medications and treatments. (Facility) staff will assist with prepping and serving of 3 meals daily from a menu of choice. He/she is diabetic but he/she does not take insulin (oral only). Resident will be served a low concentrated sweet diet and be encouraged by nursing to make good food choices. Resident August 2016 physician order sheet recorded diet: mechanical soft, with order date of 9/23/15. Interview on 9/21/16 at 11:45am with dietary staff #A, stated facility does not have any special diets. (no mechanical soft, no pureed, no thickened liquids, no gluten free diets), but does have a preferences book. Interview on 9/22/16 at 2:30pm with dietary supervisor #B, confirmed facility does not prepare any mechanically altered diets. Confirmed resident #923 does not receive a mechanical soft diet stating, " No he/she gets regular, he/she would never eat mechanical soft. " Dietary supervisor #B confirmed physician order for mechanical soft diet. Interview on 9/22/16 at 2:30pm with licensed administrative staff #C confirmed physician order for mechanical soft diet, he/she was unaware of order for mechanical soft diet and order had not be clarified with physician. For resident #923 the facility operator failed to provide health care services to the resident by	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089041	A. BUILDING: _____ B. WING _____	09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON PARK ASSISTED LIVING	1021 SW FLEMING COURT TOPEKA, KS 66604

(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 2 qualified staff in accordance with acceptable standards of practice.	S3171		