

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 Assisted Living Facility in Leawood, Kansas on 3/25/15, 3/26/15, 3/30/15, and 3/31/15. Complaints # 82158 and #84876 also investigated.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility census equalled 40 the sample included three Residents. Based on review of record and interview, for one of three sampled (#185), the Operator failed to ensure a functional capacity screen (FCS) conducted on or before admission to the facility. Findings included:	S3080		

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: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3080	Continued From page 1 - Review of record revealed #185 admitted to facility 9/30/14 with diagnoses of Congestive heart failure, Hypertension, Atrial fibrillation, Depression, Anorexia, and Protein deficiency. The medical record lacked an FCS completed on or before the Resident's admission to the facility. The medical record contained an initial FCS completed 10/01/14. This FCS assessed #185 with the need for health care services of bathing, dressing, transfers, mobility, medications and treatment management. On 3/30/15 at 3:48am Resident Care Coordinator #B confirmed the FCS for #185 completed 10/01/14, after admission to the facility. The Operator failed to ensure an FCS conducted on or before #185's admission to the facility.	S3080		
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; (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)	S3081		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 2 The census equalled 40 the sample included three Residents. Based on reviews of records and interview, for one of three sampled (#187), the Operator failed to ensure designated facility staff conducted a functional capacity screen (FCS) at least once every 365 days. Findings included: - Review of record revealed #187 admitted to facility 11/05/13 with diagnoses of Left hip fracture and pinning, Hypertension, Hyperlipidemia, Cardiovascular accident with hemiparesis, Gastroesophageal reflux disease, Migraines, Dementia, Depression, Anxiety, and Muscle spasms. The medical record contained an initial FCS completed 11/05/13. The medical record contained an FCS completed 01/08/15. Each assessed #187 in need of health care services for bathing, dressing, toileting, transfers, mobility, medications, treatments, falls/unsteadiness, and impaired decision making. On 3/26/15 at 3:41pm, Resident Care Coordinator #B confirmed the FCS completed 01/08/15, after the annual due date of 11/05/14. The Operator failed to ensure designated facility staff conducted an FCS at least once every 365 days.	S3081		
S3090 SS=E	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission.	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3090	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility census equalled 40 the sample included three Residents. Based on review of record and interview, for three of three sampled (#185, #187, and #189), the Operator failed to ensure the development of an initial negotiated service agreement (NSA) at admission. Findings included: - Review of record revealed #185 admitted to facility 9/30/14 with diagnoses of Congestive heart failure, Hypertension, Atrial fibrillation, Depression, Anorexia, and Protein deficiency. The medical record contained an initial functional capacity screen (FCS) completed 10/01/14. This FCS assessed #185 with the need for health care services of bathing, dressing, transfers, mobility, medications and treatment management; falls/unsteadiness, incontinence, and impaired decision making. The medical record contained an initial NSA "made" 10/01/14, and signed by the collaborating parties on 10/02/14 and 10/07/14. On 3/30/15 at 3:48am Resident Care Coordinator #B confirmed the NSA for #185 completed 10/02/14, after admission to the facility. The Operator failed to ensure the development of an initial NSA for #185 at admission.	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3090	Continued From page 4 - Review of record revealed #187 admitted to facility 11/05/13 with diagnoses of Left hip fracture and pinning, Hypertension, Hyperlipidemia, Cardiovascular accident with hemiparesis, Gastroesophageal reflux disease, Migraines, Dementia, Depression, Anxiety, and Muscle spasms. The medical record contained an initial FCS completed 11/05/13. This FCS assessed #187 in need of health care services for bathing, dressing, toileting, transfers, mobility, medications, treatments, falls/unsteadiness, and impaired decision making. The medical record contained an initial NSA "made" 11/05/13; never signed by Resident or the Resident's representative; signed by the previous Operator 12/02/13; signed by Resident Care Coordinator #B on 12/12/13. On 3/26/15 at 3:41pm, Resident Care Coordinator #B confirmed the original NSA never signed by Resident or their representative... stated the original was mailed to family on 11/05/13... it's really difficult to get families to sign things and return back... no documentation of attempts to get that... On 3/30/15 at 1:55pm #B stated we did the NSA later because it was a very busy time... lots of Residents with very acute needs... The Operator failed to ensure the development of an initial NSA for #187 at admission. - Review of record revealed #189 admitted to facility 7/20/14 with diagnoses of Dementia, Hypertension, Hyperlipidemia, Chronic kidney disease, Osteoarthritis, and Gastroesophageal reflux disease. The medical record contained an initial functional	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3090	Continued From page 5 capacity screen (FCS) completed 7/15/14. This FCS assessed #189 in need of health care services for medication and treatment management; falls/unsteadiness, occasional incontinence, and impaired decision making. The medical record contained an initial NSA "made" 7/20/14, and signed by the collaborating parties on 3/27/15. On 3/30/15 at 3:05pm, Resident Care Coordinator #B stated when I started doing my filing realized I did not have the original NSA... printed out another one and had everyone sign again on 3/27/15. The Operator failed to ensure the development of an initial NSA for #189 at admission.	S3090		
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	S3092		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 6 by: KAR 26-41-202(d) The census equalled 40 the sample included three Residents. Based on reviews of records and interview, for one of three sampled (#187), the Operator failed to ensure the review and if necessary the revision of each negotiated service agreement (NSA) at least once every 365 days. Findings included: - Review of record revealed #187 admitted to facility 11/05/13 with diagnoses of Left hip fracture and pinning, Hypertension, Hyperlipidemia, Cardiovascular accident with hemiparesis, Gastroesophageal reflux disease, Migraines, Dementia, Depression, Anxiety, and Muscle spasms. The medical record contained an initial FCS completed 11/05/13. The medical record contained an FCS completed 01/08/15. Each assessed #187 in need of health care services for bathing, dressing, toileting, transfers, mobility, medications, treatments, falls/unsteadiness, and impaired decision making. The medical record contained an initial NSA dated 12/12/13. This NSA documented as "made" 11/05/13, signed by Operator (Previous) 12/02/13, and by Resident Care Coordinator #B on 12/12/13. On 3/26/15 at 3:41pm, Resident Care Coordinator #B stated I completed the new FCS 01/08/15... then did not go back and do the NSA... I realized that on evening of 3/25/15 and created the new NSA... no one has signed this one yet...	S3092		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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 7 The Operator failed to ensure the review and if necessary revision of #187's NSA at least once every 365 days.	S3092		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d) The facility census equalled 40 the sample included three Residents. The facility identified 45 employees hired since the last Resurvey. Based on interviews and reviews of records, the Operator: Failed to ensure disaster and emergency preparedness by conducting quarterly reviews of the facility's emergency management plan with employees and Residents.	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 12720 STATELINE RD LEAWOOD, KS 66209		
(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
S3280	Continued From page 8 Findings included: - On 3/30/15 at 4:14pm, Operator #A stated in review of Resident council minutes, I do fire and tornado reviews every month with the Residents... do not have documentation that we review the complete disaster/emergency manual quarterly with the Residents... we had a complete review of the entire disaster/emergency manual for staff on 10/21/14, but did not complete that process quarterly since the last resurvey... The Operator failed to ensure reviews of the facility's emergency management plan completed quarterly with both employees and Residents.	S3280		