

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 Re-Licensure survey with complaint investigations 162399, 163049, 164910, 166355, 166514, 167446, 176283, 176512 for the above named Assisted Living facility conducted on 04/11/2023, 04/12/23, and 04/13/23.	S 000		
S 110 SS=E	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c)(2)	S 110		

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: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 110	Continued From page 1 The facility reported a census of 57 residents(R). The sample included three sampled residents, 2 focused record reviews, and five closed record reviews. Based in interview and record review the executive director failed to ensure that each resident or the resident's legal representative was notified in writing of any changes in charges at least 30 days before the effective date of change for two (R3, R4) of three sampled residents. Findings included: - Review of R3's medical record revealed she moved into the facility on 06/19/13 with diagnoses of bipolar disorder and history of falls. Review of R3's record included a monthly rent increase letter dated 10/04/22 which would be effective 11/01/22, giving the resident/legal representative only 28 days notice of the changes in rent charges. - Review of R4's medical record revealed he moved into the facility on 02/18/23 with diagnosis of dementia. Review of R4's record included a monthly rent increase letter dated 10/04/22 which would be effective 11/01/22, giving the resident/legal representative only 28 days notice of the changes in rent charges On 04/13/23 at 10:18 AM Administrative Staff A acknowledged the monthly rent increase letters sent out for R3 and R4 did not given a full 30 days prior to the effective date.	S 110		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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	S3028		
S3028 SS=E	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. (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)(3)(A)(C)	S3028		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 The facility reported a census of 57 residents(R). The sample included three residents, two focused record reviews, and five closed record reviews. Based on interview, and record review the operator failed to report the elopement of one (R4) of three sampled residents and one (R9) of five closed record reviews to the department within 24 hours. The operator also failed to initiate and complete a thorough investigation when R9 left the facility and went across the street to an apartment parking lot without staff being aware he left the facility. Findings included: - Review of R4's medical record revealed he moved into the facility on 02/18/23 with diagnosis of dementia. R4's admission "Functional Capacity Screen" dated 02/24/22 identified the resident had cognitive impairment and was independently mobile with use of a walker. R4's admission "Negotiated Service agreement" Dated 02/24/22 identified the resident had occasional confusion and needed occasional prompting and reorientation to daily situations. Review of the "Resident Notes" (nurse documentation) revealed the following: 08/31/22 at 05:30 PM revealed the following documentation: Residents' family came to the nurse's station at approximately 05:30 PM and asked Licensed Nurse (LN) C if I she knew where R4 was. LN C last saw the resident in the dining room at approximately 05:00 PM and R4's family saw him at 04:30 in the dining room. At	S3028		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 05:30 PM when R4 did not come back up to his room his family went looking for him and could not find him. R4's family called him, and he said he was outside looking for them. When R4's family and LN C went outside the resident was across the street in the apartment complex standing beside a car. R4 returned to the facility with his family and went to the emergency room for evaluation. Review of the resident's record included an elopement risk assessment completed on 09/01/22, after the resident had gone across the street looking for his family. On 04/12/23 at 07:43 AM LN C acknowledged she was at the facility the day the resident left the facility and walked across the street to the apartment complex. She stated the resident had not attempted to leave the facility alone before this day and would sometimes go out with family. She stated R4's family came to visit and instead of waiting in the living room for him they went up to his room and he just went outside looking for them. She acknowledged the resident had some confusion at the time they found him. She stated she called the executive director at the time as well as the director of nursing who would have done the paperwork on him leaving the property. On 04/12/23 at 12:06 PM Administrative Staff A reported that an elopement should be reported within 24 hours to the hotline and should be investigated by the facility. Review of the "Missing Resident-Elopement Policy" dated 07/2020 did not include information regarding the need to contact the state	S3028		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 department within 24 hours of the elopement. The executive director failed to report and thoroughly investigate when R4, who had cognitive impairment left the facility without staff knowledge and went across the street looking for his family. - Review of R9's medical record revealed she moved into the facility on 09/12/19 with a diagnosis of dementia. R9's "Functional Capacity screen dated 02/18/21 revealed the resident had cognitive impairment and was independent with mobility using a walker as an assistive device. R9's "Negotiated Service Agreement" dated 02/18/21 identified the resident had occasional confusion and needed occasional prompting and/or reorientation. Review of the resident's record revealed on 11/02/21 at 11:00 AM she left the facility and started walking up the street on the sidewalk. A neighbor across the street called the facility and staff went out and brought the resident back into the building. Review of the facility's investigation revealed the incident occurred on 11/02/21 and the facility did not report it to the department until 11/04/21, 2 days later. On 04/12/23 at 12:06 PM Administrative Staff A reported that an elopement should be reported within 24 hours to the hotline and should be investigated by the facility.	S3028		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 Review of the "Missing Resident-Elopement Policy" dated 07/2020 did not include information regarding the need to contact the state department within 24 hours of the elopement. The executive director failed to report and thoroughly investigate when R4, who had cognitive impairment left the facility without staff knowledge and went across the street looking for his family.	S3028		
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 reported a census of 57 residents(R). The sample included three residents, two	S3080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 7 focused record reviews, and five closed record reviews. Based on interview and record review the administrator failed to ensure one (R4) of three sampled residents had a "Functional Capacity Screen" completed by designated staff on or before admission to the assisted living facility to determine the resident's functional capacity. Findings included: - Review of R4's medical record revealed he moved into the facility on 02/18/22 with diagnosis of dementia. R4's record included an admission "Functional Capacity Screen" dated 02/24/22, six days after moving into the facility. On 04/12/23 at 03:40 PM Administrative Licensed Nurse E reported the resident moved into the facility on 02/18/22 and his "Functional Capacity Screen" should have been completed prior to or on the day he moved into the facility. The executive director failed to ensure designated staff completed an admission Functional Capacity Screen for R4, on or before admission to the facility.	S3080		
S3090 SS=D	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: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 8 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 57 residents(R). The sample included three residents, two focused record reviews, and five closed record reviews. Based on interview and record review the administrator failed to ensure one (R4) of three sampled residents had an initial "Negotiated Service Agreement" completed at admission. Findings included: - Review of R4's medical record revealed he moved into the facility on 02/18/22 with diagnosis of dementia. R4's admission "Functional Capacity Screen" dated 02/24/22 identified the resident required supervision with bathing, dressing, and toileting and was unable to manage his own medications and medical treatments. It also identified the resident had cognitive impairment and at risk for falls/unsteadiness. On 04/11/23 at 05:19 PM Administrative Licensed Nurse reported the facility document titled "Resident Functional Needs Service Plan" is their companies "Negotiated Service Agreement". Review of R4's admission "Resident Functional Needs Service Plan" was dated 02/24/22, six days after admission to the facility.	S3090		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 9 On 04/12/23 at 03:40 PM Administrative Licensed Nurse E reported the resident moved into the facility on 02/18/22 and his "Resident Functional Needs Service Plan " (Negotiate Service Agreement) should have been completed prior to or on the day he moved into the facility. The executive director failed to ensure designated staff completed an admission Negotiated Service Agreement for R4, on or before admission to the facility.	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 by: KAR 26-41-202 (d)(1)(2) The facility reported a census of 57 residents	S3092		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 10 (R). The sample included three residents, two focused record reviews, and five closed record reviews. Based on interview and record review the executive director failed to ensure staff reviewed and revised the "Negotiated Service Agreement" if necessary, for one (R3) of three sampled residents who experienced a significant change in status related to initiation of therapy services and additional outside services. Findings included: - Review of R3's medical record revealed she moved into the facility on 06/19/13 with diagnoses of major depressive disorder and history of falls. R3's "Functional Capacity Screen" dated 03/14/23 revealed the resident required physical assistance with all activities of daily living except for eating and had a current problem or risk for falls. R3's "Resident Functional Needs Service Plan" (facility's Negotiated Service Agreement") dated 03/14/23 failed to include revision when the resident started on podiatry services and when the resident started and stopped Physical and Occupation therapy services. On 04/13/23 at 01:13 PM Administrative Licensed Nurse E reported R3 received the following Physical, Occupational, and Speech therapy services from an outside resource: PT: 01/25/22 to 03/22/22 and 10/11/22 to 10/27/22 OT: 01/26/22 to 07/08/22 and 09/26/22 to 12/13/22	S3092		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 11 On 04/13/23 at 03:12 PM Administrative Licensed Nurse E acknowledged she had not revised the resident's "Negotiated Service Agreements" when they started or stopped physical therapy or another outside resource. Just if they had a significant decline or improvement in functional ability. The executive director failed to ensure designated staff reviewed and revised R3's "Negotiated Service Agreement" when she initiated physical therapy services.	S3092		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (d) The facility reported a census of 57 residents(R). The sample included three residents, two focused record reviews, and five closed record reviews. Based on record review and interview for all residents in the facility, the executive director failed to ensure three (R3, R4, R5) of three sampled resident's "Negotiated Service Agreement" included the name of the licensed nurse responsible for the implementation and supervision of the service plan.	S3165		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3165	Continued From page 12 Findings included: - On 04/11/23at 05:19 PM "Administrative Licensed Nurse" E reported all residents in the assisted living had the same format for their "Negotiated Service Agreements" and the document titled "Resident Functional Needs Service Plan" is their "Negotiated Service Agreement". - Review of R3's medical record revealed she moved into the facility on 06/19/13 with diagnosis of major depressive disorder. R3's "Functional Capacity Screen" (FCS) dated 03/14/23 identified the resident required physical assistance with activities of daily living as well as medication management. R3's "Resident Functional Needs Service Plan" (Negotiated Service Agreement) dated 03/14/23 failed to identify the name of the licensed nurse responsible for the implementation and supervision of the nursing plan. - Review of R4's medical record revealed he moved into the facility on 02/18/22 with diagnosis of dementia. R4's FCS dated 09/07/22 revealed the resident was independent with activities of daily living but at risk for falls and needed assistance with medication management. R4's "Resident Functional Needs Service Plan" (Negotiated Service Agreement) dated 06/13/22 failed to identify the name of the licensed nurse	S3165		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3165	Continued From page 13 responsible for the implementation and supervision of the nursing plan. - Review of R5's medical record revealed she moved into the facility on 09/10/22 with diagnosis of diabetes type II. R5's "Functional Capacity Screen" dated 01/14/23 revealed the resident needed supervision with bathing, and dressing and had a risk for falls. R5's "Resident Functional Needs Service Plan" (Negotiated Service Agreement) dated 01/14/23 failed to identify the name of the licensed nurse responsible for the implementation and supervision of the nursing plan. On 04/13/23 at 03:10 PM Administrative Staff A acknowledged the forms used for the "Negotiated Service Agreement" did not identify the licensed nurse responsible for the service plan. The executive director failed to ensure the name of the licensed nurse responsible for the implementation and supervision of the health care service plan was included in the negotiated service agreement.	S3165		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3166	Continued From page 14 This REQUIREMENT is not met as evidenced by: KAR-26-41-204 (e) The facility reported a census of 57 residents. Based on interview and record review of 2 newly hired Certified Medication Aides (CMA), the Administrator failed to ensure the delegation of the nursing procedure of blood sugar monitoring to each certified CMA under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto. Findings included: - On 04/17/23 at 11:05 AM Administrative Licensed Nurse E reported two residents in the facility required the facility staff to check their blood sugars. Review of employee records revealed CMA B and CMA I did not have evidence of licensed nurse delegation for blood glucose testing which is not part of the certified medication aide curriculum. On 04/12/23 at 09:48 AM Administrative staff A stated they did not have any delegation/competency for CMA doing blood sugar checks. On 04/12/23 at 09:51 AM Licensed Nurse C stated that CMA's do the blood sugar checks when a nurse is not in the building.	S3166		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3166	Continued From page 15 On 04/13/23 at 11:07 AM Administrative Licensed Nurse E acknowledged they did not have any delegation for blood sugar checks since a licensed nurse was usually in the building to check them. The Administrator failed to ensure the delegation of the nursing procedure of blood sugar monitoring to each CMA under the Kansas nurse practice act, K.S.A.65-1124 and amendments thereto.	S3166		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 57 residents. Based on observation and interview, the executive director failed to ensure all	S3211		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3211	Continued From page 16 over-the-counter medications were labeled with the resident's full name. This includes the need for the resident's full name to be on the original manufacturer's medication package and the medication container/insert. Findings included: - During initial tour of the facility on 04/11/23 at 09:22 AM Certified Medication Aide (CMA) B unlocked the medication cart for the Memory Care Unit for inspection. Observation revealed the following over-the-counter medication bottles with a resident room number on the bottle but did not include the full name of the resident: Rapid Release Acetaminophen, Calcium, PreserVision, and Low Dose Bayer Aspirin. Observation of the "Two High Side" medication cart with Licensed Nurse C on 04/11/23 at 10:00 AM revealed the following over-the-counter medications with either a room number written on it or nothing at all to identify who they belonged to: Tylenol, Claritin, Stool Softener, Metamucil, Allegra 2, and a bottle of Tums with a resident's first name written on it. Observation of the third-floor medication cart with CMA D on 04/11/23 revealed the following over-the-counter medication bottles and/or tubes without a resident's full name on them: Unisom, Osteo Bi-Flex, B complex, Calcium, Vitamin D3, Formula 4, Gas-X, Advil liquid gels, Zyrtec, Tylenol, Colace, and a tube of Cortisone 10. Observation on 04/11/23 at 10:25 AM Administrative Licensed Nurse E unlocked the "Two Low Side" medication cart which revealed	S3211		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3211	Continued From page 17 the following bottles of over-the-counter medications without a resident's full name: Vitamin D 3, Areds2 (PreserVision), Aspirin low dose, Centrum Minis, Imodium, and a bottle of Miralax. On 04/11/23 at 10:27 AM Administrative Licensed Nurse E acknowledged over-the-counter medications should have the resident's full name on the bottle for whom they belong to. The executive director failed to ensure all over the counter medications included the full name of the resident they belonged to and included the name on the original manufacturer's medication package and the medication container.	S3211		
S3240 SS=E	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the provision of staff orientation and in-service education on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This REQUIREMENT is not met as evidenced by: KAR 26-41-103 (c) The memory care facility reported a census of 57 residents and identified 28 of those residents with cognitive impairment. The facility also had a "Memory Care Unit" where 10 of the 28 cognitively impaired residents lived. Based on interview and record review the executive	S3240		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3240	Continued From page 18 director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to persons who may exhibit behaviors associated with dementia for one of five newly hired employees. . On 04/12/23 at 09:48 AM Administrative Staff A stated they use an online training for their dementia training. She provided training for four of the five newly hired employees but Certified Medication Aide B, hired on 12/28/22 had not completed any dementia training and worked routinely on the "Memory Care Unit". The executive director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to residents regarding dementia training.	S3240		
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 57 residents (R). The sample included three residents, two focused record reviews, and five closed record	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 19 reviews. . Based on interview and record review the executive director failed to ensure each resident record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken, for one (R4) of three sampled residents and one (R6) closed record review. Findings included: - Review of R4's medical record revealed he moved into the facility on 02/18/22 with diagnosis of dementia. R4's "Functional Capacity Screen" dated 09/07/22 identified the resident required supervision with bathing, dressing, and toileting and was unable to manage his own medications and medical treatments. It also identified the resident had cognitive impairment and at risk for falls/unsteadiness R4's "Resident Functional Needs Service Plan" (the facility's Negotiated Service Agreement"), dated 06/13/22 identified staff would assist with dressing and toileting when needed and Certified Medication Aides would administer medications. Review of R4's Resident notes included the following: 06/11/22 the resident had a fall in his room. The record lacked any follow up regarding status post fall. 07/10/22 the resident was on COVID isolation. The record lacked documentation of why the resident was on COVID isolation and any related possible concerns of COVID. 08/31/22 the resident left facility and walked over	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 20 to the apartment parking lot and staff did not know where the resident was. The record lacked follow up regarding the resident's status after leaving the facility without staff knowledge. 03/24/23 resident readmitted to the facility status hospitalization with compression fractures. The record lacked any follow up as to the resident's status post hospital return. On 04/12/23 at 03:04 PM Administrative Licensed Nurse E acknowledged the nurse should be following up whenever there are concerns/changes identified in resident plan of care. The executive director failed to ensure designated staff documented in the resident's record regarding fall follow up, hospitalization, what caused the resident to require COVID isolation and follow up after the resident eloped. - Review of R5's medical record revealed she moved into the facility on 09/10/22 with a diagnoses of diabetes type II. R3's "Functional Capacity Screen" dated 01/14/23 revealed the resident needed supervision with bathing and had a risk for falls. R5's "Resident Functional Needs Service Plan" (the facility's Negotiated Service Agreement") dated 01/14/23 directed staff to provide stand-by-assistance for showers, that she used a walker, and staff encourage her to slow down while walking. Review of R5's "Resident notes" (nurses notes) included the following:	S3261		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 21 12/31/22 returned from emergency department evaluation with diagnosis of new compression fractures. The record lacked follow up related to the resident's status post return with new compression fractures. 01/17/23 - home health now treating for wound care. The record lacked follow up on treatment, description and healing of wound. On 04/12/23 at 03:04 PM Administrative Licensed Nurse E acknowledged the nurse should be following up whenever there are concerns/changes identified in resident plan of care. The executive director failed to ensure designated staff documented in the resident's record regarding to follow up for return from emergency department and regarding wound care.	S3261		
S3280 SS=F	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	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 22 drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)(4) The facility reported a census of 57 residents. Based on record review and interview for all residents and all facility employees, the executive director failed to ensure disaster and emergency preparedness by ensuring performance of quarterly reviews of the facility's emergency management plan with employees and residents. Findings included: - On 04/11/23 at 08:43 AM Administrative Staff A arrived at the facility and had been informed of the purpose of the visit. She had been given a list of requested information for review, which include evidence of quarterly reviews of the Emergency Management Plan with residents and staff. On 04/11/23 at 11:38 AM Administrative Staff A stated that they have not been able to find anything in records regarding reviewing the disaster plan with resident's or staff. The executive director failed to ensure disaster and emergency preparedness by the failure to ensure the review of the emergency management plan quarterly with residents and	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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 23 staff.	S3280		
S3310 SS=E	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207(c) The facility reported a census of 57 residents(R). Based on interview and record review for five newly hired employees the executive director failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105for three of five newly hired employees. Findings included: - Review of five newly hired employee files	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S3310	Continued From page 24 revealed the following: Certified Medication Aide B hired on 12/28/22 did not have a TB symptom screen or TB skin test done until 02/01/23, more than seven days after hire date. Certified Nurse Aide G hired on 01/19/23 did not have a TB symptom screen or TB skin test done until 03/02/23, more than seven days after hire date. Licensed Nurse H hired on 08/12/22 did not have evidence of a TB symptom screen or a TB skin test in her employee file. On 04/12/23 at 10:25 AM Administrative Staff A acknowledged newly hired employees are supposed to have a TB symptom screen and skin test done upon hire. Review of the "Tuberculosis (TB) Guidelines for Adult Care Homes" dated June 2013 revealed each resident shall receive a TB symptom screen and a two-step skin test within seven days of admission. For three of five newly hired employees, the executive director failed to ensure compliance with the department's TB guidelines for adult care homes.	S3310		
S9999	Final Observations Kansas Statute 39-981. Authorized electronic monitoring; reasonable accommodations; notice; consent; use as	S9999		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S9999	Continued From page 25 evidence; prohibitions. (d) A resident, or such resident's guardian or legal representative, who wishes to conduct authorized electronic monitoring shall notify the adult care home on a form prescribed by the secretary for aging and disability services. (i) Each adult care home shall post a conspicuous notice at the entrance to the adult care home and each resident's room stating that the rooms of some residents may be monitored electronically by or on behalf of the room's resident or residents. This Requirement is not met as evidenced by: Scope and Severity of E. The facility reported a census of 57 residents(R). The sample included three residents, two focused record reviews, and five closed record reviews. Based on observation, record review, and interview, the executive director failed to ensure the proper paperwork was completed for the use of a recording electronic monitoring device in two (R11 and R12) of two resident rooms who had electronic monitoring devices in them. The executive director also failed to post a conspicuous notice at the entrance to the adult care home informing all who come into the facility that some resident room have video monitoring. Findings included: - Upon entering the facility on 04/11/23 during initial tour observation revealed a "Notice" posted around the corner by the reception desk,	S9999		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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
S9999	Continued From page 26 which is not at the entrance of the facility and not in a conspicuous area for all who enter the building to see. During Entrance review on 04/11/23 at 11:25 AM Administrative Staff A reported two residents, R4 and R11 had a video monitoring device that family had put in the resident's room. - Review of R11's record revealed she moved into the facility on 01/19/22 with diagnoses of anemia and hypertension. Observation on 04/12/23 at 10:37 AM on top of the resident's dresser in her room is a small electric monitoring device. On 04/12/23 at 10:22 AM Administrative Staff A reported they did not have any "Authorized Electronical Monitoring" (AEM) paperwork for R11 completed by her legal representative. The executive director failed to ensure the proper paperwork was completed for the use of an electronic monitoring device in R11's room. - Review of R12's medical record revealed she moved into the facility on 04/19/13 with diagnoses of osteoarthritis, heart failure and depressive disorder. Observation on 04/12/23 at 08:21 AM the resident had a video monitoring device beside the TV on the stand pointing in the direction of her recliner. On 04/12/23 at 10:22 AM Administrative Staff A provided one of the required forms for "AEM" but	S9999		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2023
NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE OF OVERLAND PARK ASSISTE			STREET ADDRESS, CITY, STATE, ZIP CODE 9201 FOSTER STREET OVERLAND PARK, KS 66212		
(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	
S9999	Continued From page 27 did not have the additional required form completed. The executive director failed to ensure the proper paperwork was completed for the use of an electronic monitoring device for R12.	S9999			