

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER JEMIGRACE HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9631 DELMAR ST OVERLAND PARK, KS 66207		
(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 represent the findings of an initial survey for the above named home plus facility conducted on 08/30/23.	S 000		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1) The facility reported a census of six residents with three included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 2 described the services provided for transfers utilizing a bed assist device.	S5105		

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: B046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER JEMIGRACE HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9631 DELMAR ST OVERLAND PARK, KS 66207		
(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
S5105	Continued From page 1 Findings included: - Record review for R2 revealed an admission date of 10/20/22 with diagnoses of Parkinson's disease and anxiety. The 10/20/22 "Functional Capacity Screen" (FCS) identified R2 required physical assistance transfers. The 10/20/22 "NSA" identified facility staff would provide assistance of one person with transfers with a gait belt. Observation on 08/30/23 at 02:37 PM revealed bilateral bed assist devices were attached to R2's bed. The "NSA" failed to describe the services provided for transfers utilizing a bed assist device. On 08/30/23 at approximately 02:37 PM Administrative Staff A and B stated R2 used the bed assist device while transferring out of bed. On 08/30/23 at approximately 03:04 PM during findings meeting Administrative Staff A and B confirmed R2's "NSA" lacked descriptions of the services provided for transfers utilizing a bed assist device. The operator failed to ensure the "NSA" for R2 described the services provided for transfers utilizing a bed assist device.	S5105		
S5126 SS=D	26-42-202 (h) NSA Signatures	S5126		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER JEMIGRACE HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9631 DELMAR ST OVERLAND PARK, KS 66207		
(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
S5126	Continued From page 2 (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 26-42-202(h) The facility reported a census of six residents with three residents included in the sample. Based on interview and record review the operator failed to obtain signatures of each individual involved in the development of the "Negotiated Service Agreement" (NSA) addendum for Resident (R) 2. Findings included: - Record review for R2 revealed an admission date of 10/20/22 with diagnoses of Parkinson's disease and anxiety. The 10/20/22 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatment; and was marked for falls, impaired vision, and impaired decision making. The 10/20/22 "NSA" identified facility staff would provide assistance of one person with bathing, dressing, toileting, transfers with a gait belt,	S5126		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER JEMIGRACE HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9631 DELMAR ST OVERLAND PARK, KS 66207		
(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
S5126	Continued From page 3 propelled her wheelchair for walking/mobility, and cut food into small pieces for eating. Facility staff managed medications and treatments. Staff kept her on a toileting schedule, and she knew to call for help if needed to prevent injury from falls. She wore glasses for impaired vision and had no special needs for impaired decision-making. Review of R2's addendums to the "NSA" revealed they were signed by the nurse but lacked signatures of the other individuals that participated in the development of the "NSA." On 08/30/22 at approximately 03:04 PM Administrative Staff A and B confirmed R2's "NSA" lacked a signature of her legal representative. The operator failed to obtain the signatures of each individual involved in the development of the "NSA" for R2.	S5126		
S5171 SS=D	26-42-204 (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 26-42-204(a) The facility reported a census of six residents with three included in the sample. Based on observation, interview, and record review the operator failed to ensure a licensed nurse completed an assessment for the purpose to use	S5171		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER JEMIGRACE HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9631 DELMAR ST OVERLAND PARK, KS 66207		
(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
S5171	Continued From page 4 bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for Residents (R) 2. Findings included: - Record review for R2 revealed an admission date of 10/20/22 with diagnoses of Parkinson's disease and anxiety. The 10/20/22 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatment; and was marked for falls, impaired vision, and impaired decision making. The 10/20/22 "NSA" identified facility staff would provide assistance of one person with bathing, dressing, toileting, transfers with a gait belt, propelled her wheelchair for walking/mobility, and cut food into small pieces for eating. Facility staff managed medications and treatments. Staff kept her on a toileting schedule, and she knew to call for help if needed to prevent injury from falls. She wore glasses for impaired vision and had no special needs for impaired decision-making. R2's record lacked evidence of a bed assist device assessment. The 08/30/23 "Resident Roster" provided by the facility documented R2 used a bed assist device. Observation on 08/30/23 at 02:37 PM revealed bilateral bed assist devices were attached to R2's bed. The left side of the bed had a bed	S5171		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER JEMIGRACE HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9631 DELMAR ST OVERLAND PARK, KS 66207		
(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
S5171	Continued From page 5 assist device that measured 10.5 inches without a cover that could not be pushed through to prevent entrapment. On 08/30/23 at approximately 03:04 PM Administrative Staff A and B confirmed there was no bed rail assessment in R2's record. The operator failed to ensure a licensed nurse completed an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for R2.	S5171		