

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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 the licensure resurvey with attached complaint number 189329 for the above named facility conducted on 07/22/24 and 07/23/24.	S 000		
S5161 SS=E	26-42-204 (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: K.A.R. 26-42-204 (d) The facility reported a census of 7 residents. The sample included 3 "Residents" (R)'s 1, 2, and 3. Based on interview and record the Operator failed to ensure the "Negotiated Service Agreements" (NSA's) contained the name of the licensed nurse responsible for the supervision and implementation of the "Health Service Plan" for R1, R2, and R3. Findings included: - Record review for R1 revealed an admission date of 08/26/21 with diagnoses of unspecified dementia, age related osteoporosis with current pathological fracture, hypothyroidism, hypertension. Review of R1's "Functional Capacity Screen" (FCS) dated 01/18/24 revealed R1 required physical assistance with bathing, dressing,	S5161		

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: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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
S5161	Continued From page 1 toileting, transferring, and walking/mobility. She was unable to feed herself and lacked the ability to manage her own medications. She had impaired short-term memory, long-term memory, memory recall and decision making. She was usually able to make herself understood and she usually understood others. She was marked as being a fall risk, having impaired decision making, having inappropriate behaviors, and she used a wheelchair mobility device. Review of R1's NSA dated 01/19/24 revealed the facility would provide the following health services: assistance with mobility, transferring, bathing toileting, dressing and management of her medications and medical treatments. In the section titled "Signatures" "00. Name and Title of the person responsible for implementing and coordinating Plan of Care" lacked the name of the nurse responsible. - Record review for R2 revealed an admission date of 08/05/21 with diagnoses of Dementia, Alzheimer's disease, Asthma, and Insomnia. Review of R2's FCS dated 01/19/24 revealed R2 required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. She was unable to feed herself and lacked the ability to manage her own medications. She had impaired short-term memory, long-term memory, memory recall and decision making. She was occasionally incontinent, and she was sometimes able to make herself understood and she sometimes understood others. She was marked as being a fall risk, having impaired vision and impaired decision making.	S5161		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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
S5161	Continued From page 2 Review of R2's NSA dated 01/19/24 revealed the facility would provide the following health services: assistance with mobility, transferring, bathing toileting, dressing and management of her medications and medical treatments. In the section titled "Signatures" "00. Name and Title of the person responsible for implementing and coordinating Plan of Care" lacked the name of the nurse responsible. - Record Review for R3 revealed an admission date of 10/31/22 with diagnoses of Vascular Dementia, cognitive deficits following other nontraumatic intracranial hemorrhage, COVID-19, age related bilateral nuclear cataracts, COVID-19, benign neoplasm of colon, calculus of kidney, carotid artery syndrome, cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries, spondylosis, adverse effect of anticoagulant antagonists. Review of R3's FCS dated 05/23/24 revealed R3 required physical assistance with bathing, dressing, toileting, transferring, and walking/mobility. She was unable to feed herself and lacked the ability to manage her own medications. She had impaired short-term memory, long-term memory, memory recall and decision making. She was incontinent, and she was sometimes able to make herself understood and she sometimes understood others. She was marked as being a fall risk and having impaired vision. Review of R3's NSA dated 05/23/24 revealed the facility would provide the following health	S5161		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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
S5161	Continued From page 3 services: assistance with mobility, transferring, bathing toileting, dressing and management of her medications and medical treatments. In the section titled "Signatures" "00. Name and Title of the person responsible for implementing and coordinating Plan of Care" lacked the name of the nurse responsible. Interview on 07/22/24 at approximately 03:00PM with Operator A and RN B confirmed the NSA's for R1, R2 and R3 lacked the name of the nurse responsible for the supervision and implementation of the health service plans. The Operator failed to ensure the NSA's contained the name of the licensed nurse responsible for the supervision and implementation of the "Health Service Plan" for R1, R2, and R3.	S5161		
S5230 SS=F	26-42-207 (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; (c) Each administrator or operator shall ensure the home ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.	S5230		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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
S5230	Continued From page 4 This REQUIREMENT is not met as evidenced by: K.A.R. 26-42-207 (c) The facility reported a census of 7 residents. The sample included 3 "Residents" and 5 newly hired employees. Based on interview and record review the Operator failed to ensure the home's compliance with the department's "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired "Registered Nurse" B and "Certified Nurse Aides" (CNA's) C and D. Findings included: - Record review for RN B revealed she began her employment on 07/01/24. The personnel record lacked documentation of the first step of the required two step TB test being administered within seven days of employment. Record review for CNA C revealed she began her employment on 06/04/24. The personnel record contained a document titled "TB skin read" and was dated 11/20/23. The test was administered on 11/20/23 and read negative on 11/22/23. The TB test was for a single step test and was greater than six months old at the time of hire for CNA C. Record review for CNA D revealed she began her employment on 06/04/24. The Personnel record contained a document titled "Minute Clinic" and revealed a single TB skin test was performed on 08/30/23.	S5230		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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
S5230	Continued From page 5 The TB test was greater than six months old at the time of hire for CNA D. Review of the facility provided policy titled "Tuberculosis, Employee Screening for" revised on 03/2021 revealed the following statements: "If the baseline test is negative and the individual risk assessment indicates no risk factors for acquiring TB, then no additional screening in indicated." "If the baseline test is positive, but the individual risk assessment is negative and the individual is asymptomatic, a second test is conducted." "The employee health coordinator (or designee) will accept documented verification of tuberculin skin test (TST) results within the preceding 12 months." Review of "Tuberculosis Guidelines for Adult Care Homes" dated 06/13 stated the following: "Each new resident and new employee shall receive a two-step TST for Mycobacterium tuberculosis within 7 days of employment unless one of the following conditions is met: A. The new resident or new employee provide satisfactory documentation of receiving the two-step TST within 6 months prior to residency or employment that read not positive." "If a new employee provides satisfactory documentation of receiving a single TST with 6 months prior to employment that read not positive, the employee shall only be required to have a single TST within 7 days of employment." Interview on 07/23/24 at approximately 03:00PM with Operator A and RN B confirmed the	S5230		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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
S5230	Continued From page 6 personnel record for RN B and CNA's C and D lacked documentation of the required two-step TB skin test being administered within 7 days of employment. The Operator failed to ensure the home's compliance with the department's TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired RN B and CNA's C and D.	S5230		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-437 (a) The facility reported a census of 7 residents. Based on observation and interview the Operator failed to ensure the facility was maintained to protect the health and safety of the facility residents when facility staff failed to ensure all chemicals were secured. Findings included: - Observation on 07/22/24 at approximately	S5335		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER MAGGIE'S PLACE AT COLONIAL VILLAGE BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 W 137TH ST OVERLAND PARK, KS 66221		
(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
S5335	Continued From page 7 11:58 AM during the initial facility tour with Operator A and "Registered Nurse" (RN) B revealed the cabinet under the kitchen sink freely opened and revealed the following unsecured chemicals: Cascade Dish Pods 1 bottle of R-T-U Glass Cleaner 1 can of Steele Cleaner Spray 1 can of Old English Spray 1 bottle of Completely One Step Virucidal 1 bottle of Pee Pee Gone Spray 1 can of Lysol Spray and 1 bottle of liquid with a damaged label with "Chem" included in the name of the liquid. Interview on 07/22/24 with Operator A revealed the cabinet under the kitchen sink should be locked to keep the chemicals secured. The Operator failed to ensure the facility was maintained to protect the health and safety of the facility residents when facility staff failed to ensure all chemicals were secured.	S5335		