

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER THE HOMESTEAD OF LENEXA		STREET ADDRESS, CITY, STATE, ZIP CODE 8740 CAENEN LAKE RD LENEXA, KS 66215		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #189401 and #182588 at the above named assisted living conducted on 12/17/24 and 12/18/24.	S 000		
S3030 SS=F	26-41-101 (g) Availability of Policies and Procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(g) The facility reported a census of 29 residents. Based on observation, interview, and record review the operator failed to ensure that policies and procedures were always available to staff and were available to others during normal business hours. Findings included: - Observation on 12/17/24 at approximately 01:10 PM during initial tour with Administrative Staff A revealed a framed sign hung on the wall at eye level between the window and door to the facility's nursing office. The sign read that	S3030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3030	Continued From page 1 policies and procedures were available at all times in the nurse's office. On 12/18/24 at approximately 01:20 PM Administrative Staff A stated the facility had very few policies. He requested state surveyor submit a list of policies needed and he would confirm with corporate staff if they had the policies. State surveyor requested five policies. On 12/18/24 at 02:17 PM Administrative Staff A stated he confirmed with Administrative Staff B that the facility did not have any policies. Their rule was to follow state regulations. On 12/18/24 at 02:23 PM Administrative Nurses C and D confirmed the facility did not have any policies and procedures to provide upon request in accordance with the sign posted on the wall between the window and door to the facility's nursing office. Administrative Nurse C stated facility staff "just follow state regulations." On 12/18/24 at 03:21 PM Administrative Staff A stated the facility did not have the policies required to open the building that were submitted during the application process for review and approval by the agency. The facility followed state regulations. On 12/18/24 at 03:30 PM Certified Medication Aide G stated she did not know where the facility's policies and procedures were located nor how to access them. She would have to ask the nurse for them. On 12/18/24 at approximately 03:50 PM Administrative Staff A stated the facility did not	S3030		

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S3030	Continued From page 2 have policies and procedures for infection control. The facility followed state regulations. A letter from the agency to all who applied to open and operate an "Assisted Living/Residential Health Care Facility" documented a list of six required policies and procedures plus three more required, if applicable, to be submitted for review and approval. The letter defined a policy was a statement that reflected the "rules" for practice to define how the facility would meet the requirements of the regulation. The letter defined a procedure was a series of steps taken to implement a policy written in a way that all users could easily follow. The operator failed to ensure that policies and procedures were always available to staff and were available to others during normal business hours.	S3030		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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;	S3085		

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S3085	Continued From page 3 and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 29 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 1 described the services provided for cognitive difficulties. Findings included: - Record review for R1 revealed an admission date of 03/04/24 with diagnoses of need for assistance with personal care and cognitive communication deficit. The 10/16/24 "Functional Capacity Screen" (FCS) identified R1 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. The 10/16/24 "NSA" failed to describe services provided R1 for cognitive difficulties. On 12/18/24 at approximately 01:27 PM Administrative Nurse C confirmed R1's "NSA" failed to describe services provided for cognitive difficulties.	S3085		

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S3085	Continued From page 4 On 12/03/24 at 10:18 AM Administrative Nurse C stated facility staff provided encouragement to R103 to keep her catheter bag below the level of her bladder, emptying of catheter bag every two hours, and reporting to the nurse if they observed sediment in her urine. Administrative Nurse C confirmed these services were not described on R103's "NSA." On 12/03/24 at 10:33 AM Administrative Staff B confirmed R103's "NSA" failed to identify the provider for assistance with dressing. On 12/18/24 at 01:20 PM an "NSA" policy was requested. Administrative Staff A stated the facility did not have an "NSA" policy. They followed state regulations. The operator failed to ensure the "NSA" for R1 described the services provided for cognitive difficulties.	S3085		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a	S3175		

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S3175	Continued From page 5 significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 29 residents with three included in the sample and one closed record review. Based on interview and record review the operator failed to ensure a licensed nurse performed an assessment to determine if Resident (R) 2 could self-administer insulin safely. Findings included: - Record review for R2 revealed an admission date of 12/04/23 with diagnoses of type two diabetes mellitus. The 10/30/24 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with management of medications. The 10/30/24 "Negotiated Service Agreement" (NSA) identified facility staff managed medications; performed a self-medication assessment quarterly and with a significant change; and supervised R2 during independent administration of insulin. R2's record lacked evidence of documentation designated staff completed a medication self-administration assessment for R2.	S3175		

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S3175	Continued From page 6 On 12/18/24 at 02:10 PM Administrative Nurse C confirmed R2's record lacked evidence of documentation designated staff completed a medication self-administration assessment. On 12/18/24 at 01:20 PM a medication administration policy was requested. Administrative Staff A stated the facility did not have a medication administration policy. They followed state regulations. The operator failed to ensure a licensed nurse performed an assessment to determine if R2 could self-administer insulin safely.	S3175		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 29 residents with three residents marked for insulin injection on the "Resident Roster." Based on interview and record review the operator failed to ensure two of three sampled Certified Medication Aides (CMA) received training and completed competencies for delegated insulin pen preparation for residents to self-administer.	S3202		

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S3202	Continued From page 7 Findings included: - Review of CMA E's record revealed a hire date of 04/01/24. Her record lacked evidence of documentation a licensed nurse completed competencies with CMA E to prepare insulin for resident self-administration correctly. Review of CMA F's record revealed a hire date of 09/18/23. Her record lacked evidence of documentation a licensed nurse completed competencies with CMA F to prepare insulin for resident self-administration correctly. On 12/18/24 at approximately 12:46 PM R2 stated the CMA's prepared insulin for her to administer to herself. On 12/18/24 at 01:25 PM Administrative Nurse C confirmed CMA E and F's records lacked evidence of documentation competencies to prepare insulin for residents self-administration was completed. On 12/18/24 at 01:20 PM a medication administration policy was requested. Administrative Staff A stated the facility did not have a medication administration policy. They followed state regulations. The operator failed to ensure all designated staff received training and completed competencies for delegated insulin pen preparation for residents to self-administer.	S3202		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents	S3261		

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S3261	Continued From page 8 (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 29 residents with three residents included in the sample and one closed record review. Based on interview and record review the operator failed to ensure licensed staff documented when Resident (R)1 returned to the facility after two hospital stays. Findings included: - Record review for R1 revealed an admission date of 03/04/24 with diagnoses of cognitive communication disorder and need for assistance with personal care. The 08/22/24 "Functional Capacity Screen" (FCS) identified R1 was unable to perform bathing, dressing, toileting; required physical assistance with transfers, walking/mobility and management of medications and treatments; was incontinent of bladder; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was marked at risk for falls. The 08/22/24 "Negotiated Service Agreement" NSA identified facility staff provided R1 total	S3261		

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S3261	Continued From page 9 assistance twice a week with bathing, assistance with dressing, toileting, transfers, and walking/mobility; management of medications and treatments; assistance with bladder incontinence; and maintenance of safe environment to prevent falls. The "NSA" failed to describe services provided for cognitive difficulties. The 03/12/24 nursing "Progress Note" documented facility staff found R1 on the floor with blood on the left side of his face and complaint of pain in the back of his head. Emergency Medical Services (EMS) transported R1 to the hospital. The 03/13/24 at 09:05 AM nursing "Progress Note" documented the hospital admitted R1 related to his fall. The 03/13/24 at 01:52 PM nursing "Progress Note" documented R1 had pacemaker placement surgery and would return to the facility after the procedure. The 04/14/24 nursing "Progress Note" documented facility staff found R1 laying on his back on the floor beside his recliner. Review of R1's record from 03/13/24 to 04/14/24 revealed lack of nursing documentation including return from hospital and monitoring of skin at the surgical site in addition to any actions taken and results of the actions. The 04/19/24 at 02:12 PM nursing "Progress Note" documented R1 had fallen twice at approximately 02:00 PM and again five minutes	S3261		

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S3261	Continued From page 10 later with no injury. R1 was unable to seek a safe way to accomplish tasks even when staff provided redirection and re-education. The 04/19/24 at 04:29 PM nursing "Progress Note" documented facility staff found R1 on the floor for the third time in one hour and complained of back pain. He refused to use the call light for assistance. EMS transferred R1 to the hospital. The 04/26/24 nursing "Progress Note" documented facility staff reported R1 had fallen, was on the floor, and complained of back pain. The nurse notified EMS to transport to hospital. Review of R1's record from 04/19/24 to 04/26/24 revealed lack of nursing documentation of return from hospital any actions taken and results of the actions. On 12/18/24 at 03:12 PM Administrative Nurse C confirmed R1's record lacked evidence of documentation regarding return from hospital on two separate occasions. She stated she expected designated staff to document when he returned from the hospital. The operator failed to ensure licensed staff documented when R1 returned to the facility after two hospital stays.	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:	S3280		

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S3280	Continued From page 11 (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)(3) The facility reported a census of 29 residents. Based on interview and record review the operator failed to provide evidence of documentation the facility's emergency management plan was reviewed quarterly with residents and staff. Findings included: - Review of the facility's emergency management plan records revealed lack of evidence of documentation designated staff reviewed the emergency management plan with residents and staff every quarter. On 12/18/24 at approximately 02:26 PM Administrative Staff A confirmed the facility's	S3280		

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S3280	Continued From page 12 record lacked evidence of documentation designated staff reviewed the emergency management plan with residents and staff every quarter. The operator failed to provide evidence of documentation the facility's emergency management plan was reviewed quarterly with residents and staff.	S3280			
S3310 SS=F	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: KAR 26-41-207(c) The facility reported a census of 29 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure the facility	S3310			

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S3310	Continued From page 13 remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Record review for Resident (R) 1 revealed an admission date of 03/04/24 with diagnoses of chronic obstructive respiratory disorder (COPD), cognitive communication deficit, and need for assistance with personal care. The 03/05/25 TB skin test documented negative results. R1's record lacked evidence of documentation facility staff administered the second step of the two-step TB skin test. On 12/18/24 at approximately 01:27 PM Administrative Nurse C confirmed R1's record lacked evidence of documentation facility staff administered the second step of the two-step TB skin test. - Record review for R3 revealed an admission date of 08/14/24 with diagnoses of weakness and repeated falls. The 08/29/24 (15 days after admission) TB skin test documented negative results. R3's record lacked evidence of documentation facility staff administered the second step of the two-step TB skin test. On 12/18/24 at approximately 02:50 PM Administrative Nurse C confirmed facility staff failed to administer R3's first step of the two-step TB skin test within seven days of admission and R3's record lacked evidence of documentation	S3310		

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S3310	Continued From page 14 facility staff administered the second step of the two-step TB skin test. - Review of Certified Medication Aide (CMA) E's employee record revealed a hire date of 04/01/24. Her record lacked evidence of documentation of the first and second steps of a two-step TB skin test. Review of CMA F's employee record revealed a hire date of 09/18/23. Her record lacked evidence of documentation of the first and second steps of a two-step TB skin test. A TB symptom screen questionnaire completed on 09/28/23 was 10 days after hire date. On 12/18/24 at approximately 01:25 PM Administrative Nurse C confirmed CMA E and F's records lacked evidence of documentation TB screening was completed in accordance with the department's guidelines. On 12/18/24 at approximately 01:20 PM a TB policy was requested. Administrative Staff A stated the facility did not have a TB policy. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee and each new resident shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment or admission. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		