

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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 citations represent the findings of the licensure resurvey with attached complaint numbers 190649, 185521, 183489, and 182830, for the above named facility conducted on 01/27/25, 01/28/25, 01/29/25 and 01/30/25.	S 000		
S3101 SS=E	26-41-202 (h) NSA Signatures (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: K.A.R. 26-41-202 (h) The facility reported a census of 85 residents. 65 residents lived in the Assisted Living section of the facility and 20 residents lived in the secured specialty section of the facility. The sample included 6 "Residents" (R)'s and 7 closed record reviews. Based on interview and record review the Administrator failed to ensure each individual involved with the development of the "Negotiated Service Agreement" (NSA) signed the agreements for R3, R6, and R7. Findings included: - Record review for R3 revealed an admission date of 10/25/21 with diagnoses of essential	S3101		

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: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3101	Continued From page 1 hypertension, overactive bladder, Alzheimer's disease, chronic kidney disease, and Sciatica. Review of R3's combined "Functional Capacity Screen/Negotiated Service Agreement/Health Service Plan" (FCS/NSA/HSP) dated 12/13/24, revealed R3 required physical assistance with bathing, dressing, toileting, transferring, and walking. R3 was independent with eating and was continent. She lacked the ability to manage her own medications and medical treatments, and had impaired short-term memory, long-term memory, memory recall and decision making. R3 was able to make herself understood and she understood others. R3 used a walker mobility device. Facility staff were instructed to provide R3 with physical assistance with bathing, dressing, and toileting, and cueing with transfers. Qualified facility staff would administer her medications, the name of the hospice provider and the nurse responsible for the implementation and supervision of the health service plan were named. The combined FCS/NSA/HSP lacked signatures of each individual involved with the development of the NSA. - Record review for R6 revealed an admission date of 01/11/23 with diagnoses of mild cognitive impairment of uncertain or unknown etiology, dementia in other diseases classified elsewhere, neutropenia, thrombocytopenia, and age-related cognitive decline. Review of R6's combined FCS/NSA/HSP dated 08/09/24, revealed R6 required physical	S3101		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3101	Continued From page 2 assistance with bathing and eating. R6 required supervision with dressing, and walking. He was independent with toileting and transferring. He lacked the ability to manage his own medications. He was continent and had impaired short-term memory, long-term memory, memory recall, and decision making. He was usually able to make himself understood and he usually understood others. He was marked at risk for falls, impaired vision, impaired hearing, wandering, and impaired decision making and used a walker mobility device. Facility staff were instructed to provide R6 with two-person physical assistance with bathing, supervision with dressing, cutting up of his food and opening cartons or packages, and administer his medications. The name of the hospice provider and the nurse responsible for the implementation and supervision of the health service plan were named. The combined FCS/NSA/HSP lacked signatures of each individual involved with the development of the NSA. - Record review for R7 revealed an admission date of 09/21/23 with diagnoses of essential hypertension, major depressive disorder, and dementia in other diseases classified elsewhere. Review of R7's combined FCS/NSA/HSP dated 12/13/24 revealed R7 was independent with bathing and transferring. R7 required physical assistance with dressing, toileting, and eating. She lacked the ability to manage her own medications and medical treatments. She was continent and had impaired shot-term memory, long-term memory, memory recall and decision	S3101		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3101	Continued From page 3 making. She was sometimes able to make herself understood and she sometimes understood others. R7 was marked at risk for falls, wandering, and impaired decision making. She used a walker mobility device. Facility staff were instructed to provide cues and prompts for safety when ambulating, administer her medications, cut up her food and open packages and containers. The name of the hospice provider and the nurse responsible for the implementation and supervision of the health service plan were named. The combined FCS/NSA/HSP lacked signatures of each individual involved with the development of the NSA. Interview on 01/30/25 at approximately 03:45 PM with Administrator C, Licensed Nurse B and Registered Nurse D confirmed the combined FCS/NSA/HSP lacked the signatures of all who were involved in the development of the NSA. The Administrator failed to ensure each individual involved with the development of the NSA's for R3, R6 and R7 signed the agreement.	S3101		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s	S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3200	Continued From page 4 recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (d) The facility reported a census of 85 residents. 65 residents lived in the Assisted Living section of the facility and 20 residents lived in the secured specialty section of the facility. The sample included 6 "Residents" (R)'s and 7 closed record reviews. Based on observation, interview, and record review the Administrator failed to ensure the facility's administration for R7 were administered in accordance with the medical providers written order and professional standards of practice. Findings included: - Record review for R7 revealed an admission date of 09/21/23 with diagnoses of essential primary hypertension, major depressive disorder, and dementia in other diseases classified elsewhere. Record review of R7's combined FCS/NSA/HSP dated 12/14/24 revealed R7 had impaired	S3200		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3200	Continued From page 5 short-term memory, long-term memory, memory recall and decision making. R7 lacked the ability to manage her own medications. "Qualified staff" were instructed to administer R7's medications twice a day. Review of R7's "Electronic Medication Administration Record" (EMAR) revealed the following medications lacked documentation for not being administered; Buspirone HCl oral tablet 5 milligrams give one tablet by mouth twice daily for anxiety, lacked documentation for being administered on 01/26/25 and 01/28/25. Hydrocodone-Acetaminophen oral tablet 5milligrams-325milligrams take one tablet by mouth three times a day, analgesic/anti-inflammatory, lacked documentation for being administered on 01/26/25 and 01/28/25. Interview on 01/30/25 at approximately 03:45PM with Administrator A, Licensed Nurse B and Registered Nurse D confirmed R7's EMAR lacked documentation for the administration of the Buspirone HCl and the Hydrocodone-Acetaminophen on 01/26/25 and 01/28/25. The Administrator failed to ensure the facility's administration for R7 were administered in accordance with the medical providers written order and professional standards of practice.	S3200		
S3215 SS=E	26-41-205 (h) Medication Storage	S3215		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3215	Continued From page 6 (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (h)(1)	S3215		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3215	Continued From page 7 The facility reported a census of 85 residents. 65 residents lived in the Assisted Living section of the facility and 20 residents lived in the secured specialty section of the facility. The sample included 6 "Residents" (R)'s and 7 closed record reviews. Based on observation, interview, and record review the Administrator failed to ensure all non-controlled medications managed by the facility were stored in separately locked compartments within a locked medication room, cabinet, or medication cart for R's 3, 6 and 7 who resided in the secured specialty area of the facility, and for R8 who resided in the assisted living area of the facility. Findings included: - Record review for R3 revealed an admission date of 10/25/21 with diagnoses of Alzheimer's disease. Review of R3's combined "Functional Capacity Screen/Negotiated Service Agreement/Health Service Plan" (FCS/NSA/HSP) dated 04/26/24 revealed R3 had impaired short-term memory, long-term memory, memory recall and decision making, R3 lacked the ability to manage her own medications. Facility "Licensed Nurses" (LN)'s and "Certified Medication Aides" (CMA)'s were instructed to administer R3's medications twice a day. Observation on 01/30/25 at approximately 09:15AM in R3's bathroom a tube of Cortisone cream on the shelf next to the sink, and in the attached cabinet another bottle of Cortisone	S3215		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3215	Continued From page 8 cream. - Record review for R6 revealed an admission date of 01/11/23 with diagnoses of age-related cognitive decline, mild cognitive impairment of uncertain or unknown etiology, and dementia in other diseases classified elsewhere. Review of R6's combined FCS/NSA/HSP dated 08/09/24 revealed R6 had impaired short-term memory, long-term memory, memory recall and decision making. R6 lacked the ability to manage his own medications. "Qualified staff" were instructed to administer R6's medications twice daily. Observation on 01/30/25 at approximately 09:25AM in R6's bathroom in the wooden tray on the counter was a bottle of Vicks Vapo Rub and a tube of Preparation H. - Record review for R7 revealed an admission date of 09/21/23 with diagnoses of essential primary hypertension, major depressive disorder, and dementia in other diseases classified elsewhere. Record review of R7's combined FCS/NSA/HSP dated 12/14/24 revealed R7 had impaired short-term memory, long-term memory, memory recall and decision making. R7 lacked the ability to manage her own medications. "Qualified staff" were instructed to administer R7's medications twice a day. Observation on 01/30/25 at approximately 09:35 AM in R7's bathroom 1 bottle of Systane Eye drops and a bottle of Skintegrity wound cleanser,	S3215		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3215	Continued From page 9 and tube of Mupirocin topical cream that was filled by the pharmacy on 07/28/21 and expired on 07/28/22. - Record review for R8 revealed an admission date of 04/29/22 with diagnoses of essential hypertension, type two diabetes mellitus without complications, bipolar disorder, adjustment disorder with anxiety, and other specified arthritis. Review of R8's combined FCS/NSA/HSP revealed she had impaired memory recall and R8 lacked the ability to manage hew own medications. Facility "staff" were instructed to provide daily assistance with R8's medication administration three times a day. Observation on 01/30/25 at approximately 09:55 AM of R8's bathroom drawers revealed the following bottles of "Over-the-Counter" medications; 1 bottle of Tylenol Arthritis, 1 bottle of Benadryl Cooling Spray, 1 bottle of Vics Vapo Rub, 1 tube of Neosporin, 1 bottle of Genteal Tears, 1 bottle of Colace tablets 100 milligrams, and 1 bottle of Senakot tablets. Review of the facility provided policy titled "Medication Administration" dated 10/2014 revealed the following; "All medications that are administered by the community staff must be securely stored and locked". Interview on 01/30/25 at approximately 03:45PM with Administrator C, Licensed Nurse B and Registered Nurse D confirmed all medications managed by the facility were to be stored in the	S3215		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3215	Continued From page 10 facility's medication carts. The Administrator failed to ensure all non-controlled medications managed by the facility were stored in separately locked compartments within a locked medication room, cabinet, or medication cart for R's 3, 6 and 7 who resided in the secured specialty area of the facility, and for R8 who resided in the assisted living area of the facility.	S3215		
S3229 SS=E	26-41-205 (I) (4) Medication Regimen Review Self Administration (I) (4) The administrator or operator, or the designee, shall offer each resident who self-administers medication a medication regimen review to be conducted by a licensed pharmacist at least quarterly and each time a resident experiences a significant change in condition. A licensed nurse shall document the resident 's decision in the resident 's clinical record. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (I)(4) The facility reported a census of 85 residents. 65 residents lived in the Assisted Living section of the facility and 20 residents lived in the secured specialty section of the facility. The sample included 6 "Residents" (R)'s and 7 closed record reviews. Based on observation, interview, and record review the Administrator failed to ensure R4 and R5 were offered a medication regimen review to be conducted by a licensed pharmacist	S3229		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3229	Continued From page 11 at least quarterly and each time they experienced a change of condition. The Administrator further failed to ensure the "Licensed Nurse" (LN) documented R4 and R5's decision in the resident's clinical record. Findings included: - Record review for R4 revealed an admission date of 09/28/22 with diagnoses of Facioscapulohumeral muscular dystrophy, essential primary hypertension, hypothyroidism, chronic pain, and chronic gout. Review of R4's "Functional Capacity Screen" (FCS) dated 01/28/25 revealed R4 required physical assistance with bathing, dressing, toileting, and transferring. He was independent with mobility and eating and managing his own medications. R4 required supervision with medical treatments. R4 had intact cognition and was continent. R4 was able to make himself understood and he understood others. R4 used a wheelchair mobility device. Review of R4's combined "Negotiated Service Agreement/Health Service Plan" (NSA/HSP) instructed facility staff that R4 was independent with his self-administration of medications. Review of R4's medical record revealed it lacked documentation of a licensed pharmacist performing a medication review at least quarterly. Review of R4's electronic "Medical Record" under the progress notes revealed it lacked	S3229		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3229	Continued From page 12 documentation of R4's decision of having a licensed pharmacist perform a medication review at least quarterly. - Record Review for R5 revealed an admission date of 03/21/22 with diagnoses of hypothyroidism, hyperlipidemia, major depressive disorder, acute angle-closure glaucoma, and essential hypertension. Review of R5's FCS dated 09/23/24 revealed R5 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. R5 was independent with the management of her medications and medical treatments. R5's cognition was intact; she was able to make herself understood and she understood others. R5 used a walker mobility device. Review of R5's combined NSA/HSP instructed facility staff that R5 was independent with her self-administration of medications. Review of R5's medical record revealed it lacked documentation of a licensed pharmacist performing a medication review at least quarterly. Review of R5's electronic "Medical Record" under the progress notes revealed it lacked documentation of R5's decision of having a licensed pharmacist perform a medication review at least quarterly. Interview on 01/30/25 at approximately 03:45PM with "Registered Nurse" (RN) D confirmed R4	S3229		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3229	Continued From page 13 and R5's medical record and electronic "Medical Record" lacked documentation they were offered a medication review from a licensed pharmacist at least quarterly. The Administrator failed to ensure R4 and R5 were offered a medication regimen review to be conducted by a licensed pharmacist at least quarterly and each time they experienced a change of condition. The Administrator further failed to ensure the "Licensed Nurse" (LN) documented R4 and R5's decision in the resident's clinical record.	S3229		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident 's family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced	S3298		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3298	Continued From page 14 by: K.A.R. 26-41-206 (d) The facility reported a census of 85 "Residents" (R). Based on observation, interview, and record review the Administrator failed to ensure the food served to residents was served at the proper temperatures. The Administrator further failed to ensure the food provided was served using safe methods that conserved the nutritive value, flavor and appearance. Findings included: - Interview on 01/27/25 at approximately 03:15PM with facility Chef A during the initial facility tour of the facility kitchen, confirmed he did not have a record of food temperatures for the assisted living or of the secured specialty unit of the facility. He stated he obtained the temperatures and did not write them down. Record review of the facility document titled "Food Council" dated 01/28/25 revealed there were 34 residents present at the meeting and on of the concerns was the "Food consistently lukewarm". Record review of the facility menu dated 01/30/25 included Pesto White Cheddar Cheese grilled cheese sandwiches, and Fire Roasted Tomato Soup. Observation on 01/27/25 at approximately 4:00PM of the food storage cabinet in the southwest side of refrigerator located in the	S3298		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3298	Continued From page 15 secured specialty unit were two large containers of peanut butter with the expiration dated of 12/29/24 and 11/10/24. In the food storage cabinet on the northwest side of the sink there was a bottle of "A-1" steak sauce and one the label on the neck of the bottle it read "Refrigerate after opening". Observation on 01/30/25 at approximately 12:00PM in the secured specialty unit, was a tray of grilled cheesed and Ruben sandwiches sitting on metal trays covered in plastic wrap on the counter. Facility staff were preparing the plates to be served. Facility Chef A obtained a temperature reading on one of the Ruben sandwiches which read 90 degrees Fahrenheit. Chef A confirmed the holding temperature should be 140 degrees Fahrenheit. Chef A sent the sandwiches back to the facility kitchen and instructed new sandwiches to be made. Observation on 01/30/25 at approximately 11:45AM facility dining staff had a cup of soup they were taking to the table for an assisted living resident; Facility Chef A obtained a temperature of the soup which read 106 degrees Fahrenheit. Chef A had instructed the facility dining staff to obtain a new cup of soup. Facility Chef A obtained a temperature of the new cup of soup which read 140 degrees Fahrenheit. Interview on 01/29/25 at approximately 01:30PM with "Licensed Nurse" B confirmed the food served to the residents was not always served at the proper temperature. Interview on 01/30/25 at approximately 08:30AM with R2's daughter confirmed the food was not	S3298		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3298	Continued From page 16 always served hot and R2 has experienced an extended wait time of up to an hour for her meal. Interview on 01/30/25 at approximately 02:30PM with R1's daughter confirmed the food served to R1 was not always warm. Review of the Department of Agriculture "Focus on Food Safety" Manuel dated 08/2017 revealed the minimum holding temperature for hot foods was 135 degrees Fahrenheit. Interview on 01/30/25 at approximately 03:15PM with Administrator A confirmed the facility lacked documentation of the food temperatures being obtained prior to the meals being served to the facility residents. The Administrator failed to ensure the food served to residents was served at the proper temperatures. The Administrator further failed to ensure the food provided was served using safe methods that conserved the nutritive value, flavor and appearance.	S3298		
S3299 SS=E	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by:	S3299		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3299	Continued From page 17 K.A.R. 26-41-206 (e) The facility reported a census of 85 "Residents" (R). Based on observation, interview, and record review the Administrator failed to ensure the food was stored in sanitary conditions. Findings included: - Observation on 01/27/25 at approximately 4:00PM of the pull-out freezer drawer of the refrigerator located on the southeast wall of the specialty unit kitchenette there were five uncovered dishes of ice cream which appeared to have partially melted and were placed back in the freezer, these five dishes lacked a date of when it was placed in the dishes. Interview on 01/27/25 at approximately 04:00PM Licensed Nurse B confirmed the five dishes of Ice Cream lacked being covered and further lacked a date of when it was placed in the dishes. Review of the Department of Agriculture "Focus on Food Safety" Manuel dated 08/2017 revealed on page 19 revealed the following; "Cold foods must be maintained at an internal temperature of 41 degrees Fahrenheit or below: date mark foods appropriately, cover foods after completely cooled, cover foods to maintain cold holding temperature", and on page 20 it stated "Must be date marked if it is Prepared on site, or commercially processed, after the original container is opened and held under refrigeration".	S3299		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3299	Continued From page 18 The Administrator failed to ensure the food was stored in sanitary conditions.	S3299		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care 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. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a) The facility reported a census of 85 "Residents" (R). 65 residents lived in the Assisted Living section of the facility and 20 residents lived in	S3320		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3320	Continued From page 19 the secured specialty section of the facility. Based on observation, interview, and record review the Administrator failed to ensure the secured specialty area of the facility was maintained to protect the health and safety of the residents. Findings included: - Observation on 01/27/25 at approximately 03:45PM of the drawers on the right side of the sink in the kitchenette area of the secured specialty unit was a container of Sani Cloth Plus Germicidal wipes. Observation on 01/30/25 at approximately 09:20AM In a resident bathroom were the following unsecured chemicals; 1 can of Total disinfectant spray, 2 cans of Love My Carpet cleaner, 1 bottle of Spic and Span spray cleaner, 1 can of Micro Ban 24-hour disinfectant, 1 package of Scrub Buddies wet cleaner cloths, and 1 can of Comet cleaner. Record review of the facility provided undated document titled "Onboarding/Expectations for Families" under the section titled "General Safety/Monitoring" revealed the following; "Please pay attention to the list of items that can be brought and kept in your loved ones apartment, as well as items that cannot be kept there-chemicals of any sort (cleaning supplies), creams/medicated, heating pads, heated blankets, space heaters, etc. are examples of thing that cannot be kept in apartments. Interview on 01/30/25 at approximately 03:15PM	S3320		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, 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
S3320	Continued From page 20 with Administrator A confirmed all chemicals were to be kept secured in the secured specialty area of the facility. The Administrator failed to ensure the secured specialty area of the facility was maintained to protect the health and safety of the residents.	S3320		