

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF LEAWOOD - IRON HC		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 W 143RD STREET LEAWOOD, KS 66224		
(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 represents the findings of a resurvey with attached incident 188172 at the above named assisted living facility conducted 06/10/25-06/12/25.	S 000		
S3028 SS=D	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.	S3028		

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

TITLE

(X6) DATE

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(D)(E)(F) The facility reported a census of 23 residents with three residents included in the sample. Based on interview and record review the administrator failed to complete appropriate corrective action, complete and submit investigation within five working days of an initial report to the department, and maintain written record of alleged exploitation. Findings included: - Record review for R2 revealed an admission date of 02/16/24 with diagnoses of dementia and generalized muscle weakness. The 02/12/25 Functional Capacity Screen (FCS) identified R2 was unable to perform management of medications and treatments; had short-term memory, memory/recall, and decision-making cognitive difficulties; and was marked for falls and impaired decision-making. The 02/12/25 NSA identified facility staff ordered and administered R2's medications. The 05/29/24 "Intake Information" documented possible drug diversion occurred on 05/28/24. A card of 30 tablets of hydrocodone was missing. An investigation was started. On 05/29/24 at 03:39 PM in an email to the department Administrative Nurse B wrote all staff would be in-serviced covering the six rights of medication	S3028		

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S3028	Continued From page 2 administration, medication diversion, residents' rights, and reporting within one week. She would complete daily audits of narcotics for 30 days, then weekly on random days for three months, then monthly thereafter. The facility's investigation and follow up of the incident was requested on 06/10/25 at approximately 10:58 AM. On 06/10/25 at 01:55 PM Administrative Nurse B confirmed she had only submitted information to compliance officer at facility's corporate office. She stated the audits were done by visual checks, no form or checklist was completed to include in record. On 06/12/25 at 10:07 AM all other information from reported incident was requested. On 06/12/25 at 11:39 AM email from Administrative Nurse B was received including "Teachable Moment" form including listed topics for staff in-service. The form failed to include any staff involved in training. The administrator failed to complete appropriate corrective action, complete and submit investigation within five working days of initial report, and maintain written record of alleged exploitation.	S3028			
S3055 SS=F	26-41-101 (I) Survey Report (I) Survey report and plan of correction. Each administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a public area to	S3055			

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S3055	Continued From page 3 residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(I) The facility reported a census of 23 residents. Based on observation and interview the administrator failed to ensure the most recent survey results were available in a common area. Findings included: - Observation on 06/10/25 at 11:16 AM during the initial tour revealed the most recent survey results were not available in a common area. On 06/10/25 at approximately 11:17 AM Administrative Nurse B confirmed the survey results were not in a common area. The administrator failed to ensure the most recent survey results were available in a common area.	S3055			
S3085 SS=E	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	S3085			

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S3085	Continued From page 4 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 26-41-202(a)(1)(2) The facility reported a census of 23 residents with three residents included in the sample. Based on interview, observation, and record review the administrator failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences for resident (R)1, R2 and R3 including a description of the services the resident received and the provider of each service. Findings included: - Record review for R1 revealed an admission date of 03/01/23 with diagnoses including epilepsy, hypothyroidism, and atrial fibrillation. The 03/04/25 FCS identified R1 required supervision with bathing; was independent with dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; had	S3085		

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S3085	Continued From page 5 decision-making difficulty; and was marked for falls and impaired decision-making. The 01/02/24 (most recent) NSA acknowledged standby or set-up assistance with bathing twice a week was provided. R1 performed dressing, transfers, toileting, walking, and eating by self. Facility staff ordered and administered medications. The NSA indicated R1 received reminders during times of forgetfulness and was encouraged to wear proper footwear when out of bed to prevent falls. The NSA failed to indicate provider of service for bathing, prevention of falls, and assistance with impaired decision making. The HSP last revised on 06/21/24 indicated to staff the caregiver is to provide standby assistance and reminders with bathing, encourage proper footwear when out of bed, keep pathways in room free of clutter, and to provide reminders with forgetfulness. Review of wellness note dated 04/05/24 at 06:35 PM documented R1 carried table from room with tray of food out of room. Staff redirected her. She then walked out of room with walker, left it outside room, and returned to room without walker. Staff again provided the reminders for safety and proper decision-making. On 06/11/25 at 03:12 PM Administrative Nurse B confirmed R1's NSA failed to list the provider of services provided for bathing, prevention of falls, and decision-making. The administrator failed to ensure R1's NSA described the services she received, and the	S3085		

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S3085	Continued From page 6 provider of the service based on her FCS. - Record review for R2 revealed an admission date of 02/16/24 with diagnoses of chronic obstructive pulmonary disease, malignant neoplasm of bronchus or lung, dementia, hypertension, and generalized muscle weakness. The 02/12/25 Functional Capacity Screen (FCS) identified R2 required supervision with bathing; was independent with dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; had short-term memory, memory/recall, and decision-making cognitive difficulties; and was marked for falls and impaired decision-making. The 02/12/25 NSA identified R2 received standby or set-up assistance with bathing twice a week was provided. R2 performed dressing, transfers, toileting, walking with walker, and eating by self. Facility staff ordered and administered medications. The NSA indicated R2 received reminders during times of forgetfulness. The NSA failed to indicate services provided to prevent falls; and provider of service for bathing, prevention of falls, and assistance with impaired decision making. The HSP last revised on 02/12/25 indicated to staff the caregiver is to provide standby assistance or set-up with bathing, ensure call light was within reach in room, encourage proper footwear when out of bed, keep pathways in room free of clutter, remind resident to lock wheels on wheelchair prior to getting in or out, and to provide reminders with forgetfulness.	S3085		

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S3085	Continued From page 7 Review of nursing note dated 03/14/24 at 02:50 PM revealed the resident attempted to open a bottle of medication with a large kitchen knife. Staff removed medication and kitchen knives from room. Review of nursing note dated 02/24/24 at 03:47 PM revealed R2 intentionally was pushing her walker into another resident's walker. Staff intervened and redirected. On 06/11/25 at 03:12 PM Administrative Nurse B confirmed R2's NSA failed to describe services to prevent falls, or list the provider of services provided for bathing, prevention of falls, and decision-making. The administrator failed to ensure R2's NSA described the services she received, and the provider of the service based on her FCS. - Record review for R3 revealed an admission date of 04/09/24 with diagnoses including lymphedema, morbid obesity, chronic kidney disease, generalized muscle weakness, cognitive communication deficit, and dysphagia. The 04/14/25 FCS identified R3 required physical assistance with bathing, management of medications, and management of treatments; was independent with dressing, toileting, transfers, walking/mobility, and eating; was occasionally incontinent of urine; and had no communication or cognitive difficulties. R3 was identified at risk of falls and/or unsteadiness. The 04/14/25 NSA identified R3 was provided	S3085		

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S3085	Continued From page 8 stand by assist with bathing without listing who provided the service. R3 transferred, dressed, toileted self, and ambulated by self with walker. Staff managed some medications. The NSA documented that R3 needed incontinence products occasionally and managed independently. The NSA failed to indicate services provided to prevent falls, and provider of service for bathing and prevention of falls. The HSP last revised on 01/01/25 indicated to staff the caregiver is to provide standby assistance with bathing twice a week, ensure call light was within reach in room, encourage proper footwear when out of bed, keep pathways in room free of clutter, and remind resident to lock wheels on wheelchair prior to getting in or out. Review of nursing note dated 05/13/24 at 02:04 PM revealed R3 completed shower with hands on assistance by staff. On 06/11/25 at 03:12 PM Administrative Nurse B confirmed R3's NSA failed to indicate services provided to prevent falls, and provider of service for bathing and prevention of falls. On 06/11/25 at 04:02 PM Administrative Nurse B confirmed the Health Care Service Plans were not given to the residents or their legal representative. The NSAs are only document given and signed. The administrator failed to ensure R3's NSA described the services she received, and the provider of the service based on her FCS.	S3085		

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S3165	Continued From page 9	S3165		
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 23 residents with three residents included in the sample. Based on record review and interview the administrator failed to ensure the Negotiated Service Agreement (NSA) for all residents listed the licensed nurse responsible for implementing and supervising their Healthcare Service Plans (HSP). Findings included: - Record review for Resident (R)1, R2, and R3 revealed the NSAs failed to name the licensed nurse responsible for implementing and supervising the HSPs. On 06/12/25 at 02:07 PM Administrative Nurse B confirmed via email the NSAs did not list the licensed nurse responsible for the HSPs. The administrator failed to ensure all residents' NSAs named the licensed nurse responsible for implementing and supervising their HSPs.	S3165		

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S3211	Continued From page 10	S3211			
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 23 residents. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eighteen over-the-counter (OTC) medications in the medication cart and storage room. Findings included: - Observation on 06/10/25 at 11:22 AM revealed the medication storage room cabinets contained the following OTC medications were not labeled with residents' full names:	S3211			

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S3211	Continued From page 11 Two bottles vitamin D3 5000 international units (IU), 400 softgels One bottle vitamin D3 1000 IU, 300 softgels One bottle vitamin D3 50000 IU, 120 capsules One bottle magnesium hydroxide 600 milligram (mg), 30 chewable bites One bottle vitamin D3 2000 IU, 400 softgels One bottle vitamin B12 1000 microgram (mcg), 60 tablets One bottle melatonin 10mg, 250 tablets One bottle docusate sodium 100 mg, 60 capsules On 06/10/25 at approximately 11:36 AM Administrative Nurse B confirmed the OTC medications were not labeled with residents' full names. - Observation on 06/10/25 at 12:09 PM revealed the medication cart contained the following OTC medications were not labeled with residents' full names: One bottle vitamin D3 1000 IU, 350 tablets One bottle vitamin B12 1000 mcg, 150 tablets One bottle Co Q10 200mg, 150 softgels One bottle acetaminophen 500 mg, 100 caplets One bottle acetaminophen 650 mg, 100 tablets One bottle lubricating eye drops, 0.4 fluid ounces One bottle vitamin B 12 1000 mcg, 200 tablets One bottle melatonin 5 mg, 90 tablets One bottle Biotin 5000 mcg, 150 softgels On 06/10/25 at approximately 12:12 PM Administrative Nurse B confirmed the OTC medications were not labeled with residents' full names.	S3211		

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S3211	Continued From page 12 Observation on 06/10/25 at approximately 12:10 PM Certified Medication Aide D got out a marker and wrote residents' names on bottles of medications. On 06/10/25 at approximately 12:10 PM Certified Medication Aide D stated the CMA's labeled OTC medications with residents' names. On 06/10/25 at 11:44 PM Administrative Nurse B stated her expectation is that the CMAs labeled OTC medications with residents' names when they arrive to facility. The facility's "Storage of Medication" policy dated 03/2022 read containers with missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The policy fails to instruct staff what to do with medications received from sources other than a pharmacy. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of eighteen OTC medications.	S3211		
S3213 SS=D	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14.	S3213		

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S3213	Continued From page 13 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(2) The facility reported a census of 23 residents. Based on observation and interview the administrator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container of four medications. Findings included: - Observation on 06/10/25 at approximately 11:28 AM revealed the medication storage cabinet contained one bottle 100 tablets of hydralazine hydrochloride 50 milligrams not labeled with a resident's full name, furthermore a pharmacy affixed label. On 06/10/25 at approximately 11:33 AM Administrative Nurse B confirmed the medication was not labeled with a pharmacist affixed label. The administrator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S3213			
S3215 SS=F	26-41-205 (h) Medication Storage (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.	S3215			

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S3215	Continued From page 14 (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: KAR 26-41-205(h) The facility reported a census of 23 residents. Based on observation and interview the administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations, the pharmacy provider, or those of federal and state laws and regulations.	S3215		

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NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF LEAWOOD - IRON HC		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 W 143RD STREET LEAWOOD, KS 66224		
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S3215	Continued From page 15 Findings included: - Observation on 06/10/25 at 11:22 AM of the medication storage room cabinets contained the following medications were expired: One bottle potassium chloride 10 milliequivalents, 90 tablets expired 01/20/25 One bottle Warfarin 1 milligram (mg), 60 tablets expired 05/14/25 One bottle carvedilol 3.125mg 200 tablets expired 3/18/25 One bottle amlodipine 5mg, 200 tablets expired 1/30/25 One bottle fluoxetine 20 mg, 90 capsules expired 2/14/25 On 06/10/25 at approximately 11:32 AM Administrative Nurse B confirmed the medications were expired per pharmacy or manufacturer's label. - Observation on 06/10/25 at 11:28 AM in the medication storage room revealed a refrigerator that contained two boxes of 10 syringes each Fluad influenza vaccines with expiration dates of 05/02/25 and 05/27/25. On 06/10/25 at approximately 11:32 AM Administrative Nurse B confirmed the medications were expired per manufacturer and could be used for any resident. - Observation on 06/10/25 at 11:14 AM of the medication cart, unlocked by Certified Medication Aide C, contained one bottle simvastatin 40mg expired 3/18/25 and one bottle Nystatin powder	S3215		

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S3215	Continued From page 16 100,000 units per gram with date of use by 02/26/25. On 06/10/25 at approximately 11:32 AM Administrative Nurse B confirmed the medications were expired per pharmacy or manufacturer's label. The facility's "Storage of Medication" policy dated 03/2022 documented discontinued, outdated, or deteriorated drugs were not to be used. The administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations or those of federal and state laws and regulations.	S3215			
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 23 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, and other	S3261			

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S3261	Continued From page 17 indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 2 developed a rash, had medications ordered for nausea and dry eye, and R3 was transferred out of facility. Findings included: - Record review for R2 revealed an admission date of 02/16/24 with diagnoses of chronic obstructive pulmonary disease, malignant neoplasm of bronchus or lung, hypertension, dementia and generalized muscle weakness. The 02/12/25 Functional Capacity Screen (FCS) identified R2 required supervision with bathing; was independent with dressing, toileting, transfers, walking/mobility, and eating; was unable to perform management of medications and treatments; had short-term memory, memory/recall, and decision-making cognitive difficulties; and was marked for falls and impaired decision-making. The 02/12/25 NSA identified R2 received standby or set-up assistance with bathing twice a week was provided. R2 performed dressing, transfers, toileting, walking with walker, and eating by self. Facility staff ordered and administered medications. The NSA indicated R2 received reminders during times of forgetfulness. Review of progress note dated 05/16/25 at 11:26 PM by local provider revealed R2 developed rash and itching to both sides of her face. Review of "Consultant Pharmacist Recommendations to MD" dated 10/03/24 revealed the local provider discontinued Zofran	S3261		

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S3261	Continued From page 18 for nausea and vomiting and Olopatadine Hydrochloride eye drops for dry eyes. Review of R2's medication administration record for June of 2025 revealed Olopatadine Hydrochloride (HCl) was ordered on 12/27/24 and Ondansetron HCl (generic medication for Zofran) was ordered on 03/09/25. Review of nursing and wellness notes revealed last written note was on 07/24/24. R2's record revealed lack of evidence of documentation of all illnesses including the date and time of occurrence, action taken, and results of the action when she developed rash and itching to both sides of her face and when Olopatadine HCl and Ondansetron HCl were ordered. On 06/11/24 at approximately 03:15 PM Administrative Nurse B confirmed R2's record lacked evidence of documentation of symptoms and indications of illness including the date and time of occurrence, action taken, and results of the action. - Record review for R3 revealed an admission date of 04/09/24 with diagnoses including lymphedema, morbid obesity, chronic kidney disease, generalized muscle weakness, cognitive communication deficit, and dysphagia. The 04/14/25 FCS identified R3 required physical assistance with bathing, management of medications, and management of treatments; was independent with dressing, toileting, transfers, walking/mobility, and eating; was occasionally incontinent of urine; and had no communication or cognitive difficulties. R3 was	S3261		

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S3261	Continued From page 19 identified at risk of falls and/or unsteadiness. The 04/14/25 NSA identified R3 was provided stand by assist with bathing without listing who provided the service. R3 transferred, dressed, toileted self, and ambulated by self with walker. Staff managed some medications. Review of wellness notes revealed on 03/18/25 at 02:02 PM R3 returned from hospital. The previous note dated 03/15/25 at 03:43 PM documented R3 complained of diarrhea, nausea, and being light-headed. R3's record revealed lack of evidence of documentation of all illnesses including action taken and results of the action when she was transferred out of the facility. On 06/11/24 at approximately 03:15 PM Administrative Nurse B confirmed R3's record lacked evidence of documentation of illness including action taken and results of the action. The administrator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 2 developed a rash, had medications ordered for nausea and dry eye, and R3 was transferred out of facility.	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	S3280		

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S3280	Continued From page 20 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 23 residents. Based on record review and interview the administrator failed to ensure disaster and emergency preparedness by ensuring quarterly review of the facility's emergency management plan with all staff and residents. Findings included: - On 06/10/25 at 11:01 AM the facility's quarterly reviews of the emergency management plan with all staff and residents were requested since the last survey. Observation on 06/12/25 at 12:32 PM an Emergency Operations binder was noted to be in the cabinet of the staff's work room which included two quarterly reviews. The review titled "Quarterly Disaster Readiness Review	S3280		

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S3280	Continued From page 21 (Residents)" dated 01/25/24 included eight residents and the review dated 05/16/24 included five staff and seven residents. On 06/12/25 at 11:39 AM a quarterly review dated 01/29/24 was received via email from Administrative Nurse B which included nine residents (five were same as 01/25/24) and three staff. The facility failed to review the emergency management plan with all potential emergencies with all residents and all staff for the first and second quarters of 2024. The facility failed to provide documentation regarding emergency management plan reviews with staff and residents for the third and fourth quarter of 2024 and the first or second quarter of 2025. The facility's "Emergency Operations Plan" (EOP) dated 08/13/24 recorded education and training of the EOP is completed upon orientation and annually to staff in compliance with state regulation. The administrator failed to ensure disaster and emergency preparedness by ensuring quarterly review of the facility's emergency management plan with all staff and residents.	S3280		
S3296 SS=F	26-41-206 (c) (1) Dietary Services Weekly Menu (c) (1) Menu plans shall be available to each resident on at least a weekly basis.	S3296		

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S3296	Continued From page 22 This REQUIREMENT is not met as evidenced by: KAR 26-41-206(c)(1) The facility reported a census of 23 residents. Based on observation and interview the administrator failed to ensure the menu was available to all residents on at least a weekly basis. Findings included: - Observation on 06/10/25 at approximately 12:28 PM revealed a weekly menu was not posted for residents to access. During entrance interview Administrative Staff A stated only a daily menu is posted. On 06/10/25 at 12:28 PM Certified Nurse Aide D confirmed a weekly menu was not available to the residents. On 06/10/25 at 02:22 PM R1 stated she has never seen a weekly menu, only daily. On 06/10/25 at 03:16 PM R2 stated she has had a daily menu and never remembered seeing a weekly menu. The administrator failed to ensure a weekly menu was available to all residents.	S3296			
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions.	S3299			

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S3299	Continued From page 23 (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: KAR 26-41-206(e) The facility reported a census of 23 residents. The facility had a kitchen where food was stored and served to all residents. Based on observation and interview the administrator failed to ensure food items were stored under safe conditions. Findings included: - Observation on 06/10/25 at 12:18 PM in the kitchen revealed a refrigerator that contained the following food items for the residents: One container Chobani coffee creamer without opened date One can whipped topping without opened date and best by date of 05/25/25 One individual serving container Chobani yogurt with best by dated of 01/30/25 One saran wrapped package of hard and discolored sliced yellow cheese without opened date One disposable bowl with 3 boiled eggs without date prepared On 06/10/25 at 12:18 PM Certified Medication Aide C confirmed the food items lacked labels	S3299		

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S3299	Continued From page 24 identifying what was inside, a date the food was opened or prepared, and/or was past the best by date. The 2024 Kansas Department of Agriculture's "Focus on Food Safety" booklet Page 21 explains foods must be date marked when commercially prepared and the original container was opened and held under refrigeration or when prepared on-site. Food could be held for seven days at 41 degrees Fahrenheit or less. The administrator failed to ensure foods were stored under safe conditions.	S3299			
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)	S3310			

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S3310	Continued From page 25 The facility reported a census of 23 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two newly hired staff. Findings included: - Review of Certified Medication Aide (CMA) G's employee record revealed a hire date of 11/06/24 and prior TB testing from March of 2024. The record lacked evidence of documentation of TB testing upon hire. The results were requested which the facility failed to provide. - Review of Certified Medication Aide (CMA) H's employee record revealed a hire date of 04/30/25. The "TB Skin Test Consent Form" had step 1 administered on 04/28/25 with no result date or a second step administered. On 06/10/25 at 02:50 PM Administrative Staff I confirmed via email the employee records lacked evidence of completed TB testing per guidelines. 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 within seven days of employment. The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes	S3310		

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S3310	Continued From page 26 adopted by reference in KAR 26-39-105.	S3310		
S3320 SS=F	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: KAR 28-39-254(a) The facility reported a census of 23 residents. Based on observation and interview the administrator failed to ensure the facility was maintained to protect the health and safety of the	S3320		

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S3320	Continued From page 27 residents and visitors by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 06/10/25 at 11:58 AM of the public bathroom revealed one 160 wipe container of micro-kill one germicidal alcohol wipes with label that said, "Keep out of reach of children" on the sink counter. On 06/10/25 at 12:02 PM the laundry door was propped open. In the sink was one gallon container of liquid laundry detergent. Located under the counter were three-drawer storage containers. Located in a drawer was a container of 160 wipes of sani-cloth plus germicidal wipes. Both labels read, "Keep out of reach of children." On 06/10/25 at 12:30 PM Certified Medication Aide C and Certified Nurse Aide D stated the laundry door stays open and unlocked for the residents. On 06/10/25 at 12:42 PM Administrative Nurse B confirmed the laundry detergent dispenser was broke and the detergent was located in the sink where it was not secured. She confirmed the chemicals were not stored in locked areas. The facility's "Safe Use and Storage of Chemicals" policy dated 04/23 instructed staff to keep all cleaning products, chemicals, or agents containing "Keep out of the reach of children" secured and stored in locked cabinets or closets. The administrator failed to ensure the building was maintained to protect the health and safety	S3320		

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S3320	Continued From page 28 of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		
S3420 SS=F	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be	S3420		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF LEAWOOD - IRON HC		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 W 143RD STREET LEAWOOD, KS 66224		
(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
S3420	Continued From page 29 as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256(c)(1)(A) The facility reported a census of 23 residents. The sample included three residents. Based on observation and interview the administrator failed to ensure the facility heating, air conditioning, and ventilating system maintained an indoor temperature between 70 and 85 degrees Fahrenheit (F). Findings included: - During initial tour on 06/10/25 at 11:50 AM residents were seen sitting in dining area waiting for lunch meal. One resident stated, "welcome to Iceland." She stated she is "passed cold." Air temperature in room 66.9 degrees F. All residents had access to the dining room at all times. Observation on 06/10/25 at 01:27 PM of dining area revealed air temperature of 65.5 degrees F and cold air continued to blow from vents. Observation on 06/11/25 at 11:17 AM of dining area revealed two residents waiting for meal with	S3420		

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S3420	Continued From page 30 two long-sleeved layers to upper bodies. Unlicensed staff E stated, "it's chilly in here." Observation on 06/11/25 at 03:34 PM revealed air temperature of 69.6 degrees F at the thermostat. The thermostat is inside a locked plastic case and read 80 degrees with setting of "cool to" 73 degrees F. Warm air felt coming from holes on lower side of the box. Interview on 06/10/25 at 01:39 PM of R4 revealed the "biggest complaint" from residents is the cold temperature in the dining room. He stated most residents "go back and get a sweater or coat" from room before eating their meals. Interview on 06/11/25 at approximately 02:00 PM of R3 revealed she likes air temperature around 73 degrees F. She stated the dining room is too cold and "at supper I have to wear a coat." Interview on 06/11/25 at 02:30 PM of R1 revealed she feels cold in the dining room all year round. Interview on 06/11/25 at approximately 03:16 PM of R2 revealed she always feels cold in the dining room. She stated, "everyone has to wear jackets." She also stated it has been complained about many times. Interview on 06/11/25 at 03:44 PM Maintenance Staff F confirmed he has worked on regulating the temperature in the dining area and knew it was a problem. The administrator failed to ensure the facility heating, air conditioning, and ventilating system	S3420		

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S3420	Continued From page 31 maintained an indoor temperature between 70 and 85 degrees Fahrenheit (F).	S3420			