

Kansas Department for Aging and Disability Services

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| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>07/30/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>WESTCHESTER VILLAGE OF LENEXA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                    |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8505 PFLUMM ROAD , LENEXA, Kansas, 66215</b>                                 |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| S0000                                                                | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                    | S0000               |                                                                                                                          |  |                                                 |  |
| S3085<br>SS = F                                                      | <p>The following represent the findings of a resurvey for the above-named Assisted Living facility conducted on 07/29/26 and 07/30/26.</p> <p>Negotiated Service Agreement</p> <p>CFR(s): 26-41-202 (a)</p> <p>(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:</p> <p>(1) A description of the services the resident will receive;</p> <p>(2) identification of the provider of each service; and</p> <p>(3) identification of each party responsible for payment if outside resources provide a service.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>26-41-202 (a) (1) (2) (3)</p> <p>The facility reported a census of 37 residents with three residents included in the sample. Based on record review and interview the facility 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)102, and R103 and for residents who required health care services, contained a description of the services the resident received, identified the provider of each service and identified the party responsible for payment if services were provided by an outside provider for R102 and R103.</p> <p>Findings included:</p> |                                                    | S3085               |                                                                                                                          |  |                                                 |  |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |  | TITLE | (X6) DATE |
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Kansas Department for Aging and Disability Services

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WESTCHESTER VILLAGE OF LENEXA</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                       |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>8505 PFLUMM ROAD , LENEXA, Kansas, 66215</b> |                                                                                                                          |                                                     |                            |
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| S3085<br>SS = F                                                          | <p>Continued from page 1</p> <p>- R102's medical record revealed he moved into the facility on 03/09/26 with a diagnosis of amyotrophic lateral sclerosis (ALS).</p> <p>The 06/26/26 FCS identified R102 required physical assistance with bathing, dressing, toileting, transfers, management of medications, and management of treatments.</p> <p>The 06/26/26 NSA was a separate document from the "Health Care Service Plan " (HCSP) and did not identify services provided, or the provider of each service. The NSA identified R102 received services from a local hospice provider but did not identify who was responsible for payment of services provided by an outside provider.</p> <p>On 07/30/26 at 12:09 PM Administrative Nurse A confirmed the NSA did not address management of medical treatments, that R102's NSA did not identify who provided services and who was responsible for payment of these services.</p> <p>The facility failed to ensure R102's NSA was fully developed to include the services provided, the provider of each service and identify the party responsible for payment of services provided by an outside service provider.</p> <p>- R103's medical record revealed he moved into the facility on 05/02/25 with a diagnosis of type two diabetes mellitus.</p> <p>The 01/31/26 FCS identified R103 required physical assistance with bathing, and management of treatments.</p> <p>The 01/31/26 NSA was a separate document from the HCSP and did not identify services provided, or the provider of each service. The NSA identified R103 received services from a local hospice provider but did not identify who was responsible for payment of services provided by an outside provider. On 07/30/26 at 12:34 PM Administrative Nurse A confirmed the NSA did not address management of medical treatments, that R103's NSA did not identify who provided services and who was</p> |                                                       |  | S3085                                                                                        |                                                                                                                          |                                                     |                            |

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| S3085<br>SS = F                                                          | Continued from page 2<br>responsible for payment of these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | S3085                                                 |                                                                                                                          |                                                                                              |  |                                                     |  |
| S3175<br>SS = D                                                          | <p>The facility failed to ensure R103's NSA was fully developed to include the services provided, the provider of each service and identify the party responsible for payment of services provided by an outside service provider.</p> <p>Self Administration of Medication</p> <p>CFR(s): 26-41-205 (a) (1)</p> <p>(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.</p> <p>(1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>3175</p> <p>KAR 26-41-205(a)(1)</p> <p>The facility reported a census of 37 residents. The sample included three residents. Based on observation, interview and record review, the facility failed to ensure one of three sampled residents medical records contained documentation of a completed medication self-administration assessment.</p> <p>Findings included:</p> <p>-R101's medical record revealed she moved into the facility on 06/15/26 with a diagnosis of osteoarthritis.</p> <p>The 06/15/26 "Functional Capacity Screen" (FCS) documented R101 was independent with the management of her medications.</p> | S3175                                                 |                                                                                                                          |                                                                                              |  |                                                     |  |

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| S3175<br>SS = D                                                          | <p>Continued from page 3</p> <p>The 06/15/26 "Negotiated Service Agreement" (NSA) documented R101 managed her medications independently.</p> <p>Review of R101's medical records failed to locate a completed medication self-administration assessment.</p> <p>On 07/30/26 at 11:30 AM an observation of R101's apartment revealed there was a pill organizer in her kitchen containing her medications.</p> <p>On 07/30/26 at 11:30 AM R101 stated she independently administered her own medications.</p> <p>On 07/30/26 at 11:45 AM Administrative Staff A stated the self-administration of medication assessment was completed at admission for R101 and family but was not entered in the computer.</p> <p>The facility failed to ensure a medication self-administration assessment was completed for R101.</p> |                                                       |  | S3175                                                                                        |                                                                                                                          |                                                     |                            |