

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046071	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2026
NAME OF PROVIDER OR SUPPLIER HEMSLEY HOUSE ASSISTED LIVING & MEMORY CAF		STREET ADDRESS, CITY, STATE, ZIP CODE 15055 WEST 87TH ST PARKWAY LENEXA, KS 66215		
(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 complaint 198344, 197837, and 197660 at the above-named assisted living facility conducted on 09/02/26 and 09/03/26. The facility reported a census of 58 residents with five included in the sample.	S 000		
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 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)(4) Based on interview and record review the facility failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with all residents and staff and further failed to ensure	S3280		

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

TITLE

(X6) DATE

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S3280	Continued From page 1 the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation quarterly reviews were completed with residents since the last survey and with staff during the second quarter of 2026. On 09/02/26 at 04:16 PM Administrative Staff A confirmed the facility's records lacked documentation reviews of the emergency management plan were completed quarterly with all residents and staff. The facility's 04/01/14 "Evacuation Preparedness" policy failed to indicate training provided to staff and residents with frequency. The administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with all residents and staff. - On 09/02/26 at 01:43 PM the facility's last two annual evacuations were requested which the facility failed to provide. On 09/02/26 at 04:16 PM Administrative Staff A confirmed the records lacked documentation a full evacuation was completed annually. The facility's 04/01/14 "Evacuation Preparedness" policy failed to indicate training provided to staff and residents with frequency. The facility failed to ensure disaster and	S3280			

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S3280	Continued From page 2 emergency preparedness by the failure to ensure the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location.	S3280			