STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046043	A. BUILDING: _____ B. WING _____	07/08/2016

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THE HOMESTEAD OF LENEXA	8740 CAENEN LAKE RD LENEXA, KS 66215

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S 000	INITIAL COMMENTS The following citations are the result of a licensure re-survey at the above named assisted living facility in Lenexa, Kansas on 7/5/16, 7/6/16, 7/7/16 and 7/8/16.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 28 residents. The sample included 3 residents. Based on record review, observation and interview for 2 (#705 and #706) sampled residents requiring health care services, the operator failed to ensure that a licensed nursed provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #705 recorded admission date of 5/9/16 with diagnoses including: hypertension, hyperlipidemia, restless leg syndrome, folate deficiency anemia and	S3155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3155	Continued From page 1 GERD (gastroesophogeal reflux disease). Functional Capacity Screen (FCS) dated 5/9/16 recorded resident required assistance with management of medications and treatments and had difficulty with short term memory and memory recall and had a history of falls. Negotiated Service Agreement/ Health Care Service Plan (NSA/HCSP) dated 5/9/16 recorded resident to receive assistance with medications and treatments and resident has problems with memory and memory recall. Observation during interview with resident on 7/6/16 at 1:35pm in resident ' s room revealed a bed cane attached to the right side of resident ' s bed. Bed cane was pulled away from the edge of the bed approximately 6-7 inches and was loose. Resident stated, " I probably use it, I can ' t think right now. " Interview on 7/6/16 at 3:50pm with licensed staff #R confirmed resident fell at home and NSA/HCSP lacked documentation for fall interventions and use of bed cane. Record review for resident #706 recorded admission date of 3/9/16 with diagnoses including: Hypertension, generalize anxiety disorder, complex regional pain syndrome of lower limb bilateral, GERD, constipation and insomnia. FCS dated 3/9/16 recorded resident required assistance with bathing, dressing and toileting; supervision with management of medications and treatments and is incontinent of bladder. NSA/HCSP dated 3/9/16 recorded resident to	S3155		

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S3155	Continued From page 2 receive assistance bathing, dressing and toileting and supervision with medications and treatments. Review of Clinical Notes report dated 3/9/16 recorded resident to receive PT/OT (physical therapy/ occupational therapy), 7/1/16 recorded that on 6/27/16 resident was admitted to hospice. Observation during interview with resident on 7/6/16 in resident ' s room, revealed 2 half rails on resident ' s bed. Resident stated, " I have to have that rail to get in and out on the left side. Hospice brought that one in (bed with rails) " . The NSA/HCSP lacked documentation of services by outside providers, and use of side rails. Interview on 7/6/16 at3:35pm with licensed staff #R confirmed resident received PT/OT and received hospice care, NSA/HCSP lacked documentation for outside providers of PT/OT and hospice and use of side rails. He/she was unaware resident had side rails on the bed. He/she further confirmed lack of assessments for use of side rails and lack of safety checks of side rails for both residents. For 2 (#705 and #706) sampled residents requiring health care services, the operator failed to ensure that a licensed nursed provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement.	S3155		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness	S3280		

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S3280	Continued From page 3 (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 26-4-104(d)(3) The census equaled 28 residents, the sample included 3 residents. Based on observation, interviews and review of records, for all residents, the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure all staff knew door codes to allow exit through locked doors that did not contain delayed egress locks and further failed to ensure quarterly review of the facility ' s emergency management plan with employees and residents. Findings included:	S3280		

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S3280	Continued From page 4 On 7/5/16 during facility tour from approximately 1:00pm to 4:00 pm the following was observed: All facility exit doors (except front entry door) failed to open after pushed on for 15 seconds. All exit doors open with keypad code entered, but no alarm sounded. Review of letter dated 4/24/15 to (facility) from Kansas State Fire Marshall, recorded approval for facility emergency doors that do not contain delayed egress locks. Compliance email dated 4/8/16 detailed steps to ensure resident safety compliance: " 4) Each facility that does not have emergency egress, has an emergency release switch and signage (see photo) at a commonly staffed area. " " 6) All staff will be in-serviced on emergency procedures and know door codes. " On 7/5/16 at 3:05pm request made for certified staff #V to open an exit door with the code. He/she stated it was one of two codes and was not sure which one opened that exit door. He/she was able to open door on first attempt. He/she stated he/she was not trained on doors. On 7/5/16 at 3:15pm request made for certified staff #W to open an exit door with the code. He/she stated " I don ' t know them by heart " , then entered codes 6 times and was unable to open the exit door. He/she stated he/she had not been in-serviced on doors.	S3280		

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S3280	Continued From page 5 On 7/5/16 at 3:48pm request made for certified staff #X to open an exit door with the code. He/she stated the code was written backwards on the fire pull. He/she entered codes several times and was unable to open the exit door. He/she then stated the exit door would open if it was pushed on hard for 15 seconds. He/she was unable to open the exit door. On 7/5/16 at 5:08pm requested from administrative staff #S the facility policy on exit doors. He/she stated the facility does not have a policy on exit doors. On 7/5/16 at 5:20pm administrative staff #S provided a plan for staff training regarding exit door code panels, what to do if they do not work and how to release the doors in case of an emergency. On 7/6/16 at 9:25am during review of disaster and emergency management with administrative staff #S, records provided for one staff training on 6/7/16, one resident training on 2/5/16, and one emergency evacuation drill with residents on 8/4/15. Administrative staff #S stated it is scheduled once a year, he/she did not know it needed to be done quarterly. He/she also stated " we called every employee last night about the door codes and in-serviced staff this morning. " On 7/6/16 at 5:15pm request made for certified staff #V to enter code to release an exit door. He/she was able to do so. Request made to indicate where emergency door release was	S3280		

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S3280	Continued From page 6 located, he/she was unable to locate the switch in the fire panel area, and stated he/she was not in-serviced on the emergency release switch. On 7/6/16 at 5:20pm request made for certified staff #X to enter code to release an exit door. He/she was able to do so. Request made to indicate where emergency door release was located; he/she was unable to locate the switch in the fire panel area. On 7/6/16 at 5:30pm request made for administrative staff #S to indicate where the emergency door release was located. He/she indicated a fire pull on the wall (located beneath the fire panel) with a key in it, in the nurses station. A sign on the fire panel read: " Emergency Door Release- Pull handle alarm will sound and exit doors will release " Review of Staff in-service dated 6/7/16, Topics: fire safety, emergency, alarms, staff competency with drills, elopements and tornado procedures. 19 facility staff signed as having attended. Administrative staff #S confirmed in-service lacked training for codes to open exit doors and location of emergency door release switch. For all residents, the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure all staff knew door codes to allow exit through locked doors that did not contain delayed egress locks and further failed to ensure quarterly review of the facility ' s emergency management plan with employees and residents.	S3280		

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S3290 SS=D	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(a)(c) The facility reported a census of 28 residents. The sample included 3 residents. Based on observation, record review and interview for 1	S3290		

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S3290	Continued From page 8 (#707) resident receiving a mechanically altered diet and/or thickened liquids, the operator/nurse failed to ensure a medical care provider's order shall be on file in the resident's clinical record and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. Findings included: Record review for resident #707 recorded admission date of 10/8/15 with diagnoses of dementia, gastroesophogeal reflux disease and dry eye syndrome. Functional capacity screen dated 3/18/16 recorded resident independent with eating and required physical assistance with meal preparation. Negotiated service agreement/health care service plan dated 3/18/16 recorded meal preparation, physical assistance needed, diet consistency pureed, three meals per day. Special dietary needs/preferences: " (resident) is now on a pureed diet. Staff will offer puddings, jello, plain soups, etcetera for snacks and meal supplements if he/she won ' t eat the pureed food. " July 2016 physician order sheet recorded diet: pureed.	S3290		

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S3290	Continued From page 9 Interview on 7/5/16 at 3:32 pm with dietary staff #T stated he/she did not have instructions for resident ' s pureed diet, " We use the processor with milk and blend it to a milkshake consistency. " Observation on 7/6/16 at 12:30pm in the facility dining room revealed resident seated at table with a green bowl of orange pureed food in front of him/her. Other residents have a meal of baked potato, carrots and a meat in front of them. Interview on 7/6/16 at 12:30pm with dietary staff #T confirmed he/she pureed all of resident ' s meal together and served it in one bowl. Observation on 7/6/16 at 12:40pm revealed certified staff #U state loudly, " He/she didn ' t get no dessert! " , while handing an ice cream sandwich to resident #707, resident then ate it. Other residents had a slice of cream pie in front of them. Interview on 7/6/16 at 3:50pm with licensed staff #R confirmed lack of pureed diet preparation instructions signed by a licensed dietician or physician for resident #707. Interview on7/6/16 at 3:10pm with administrative staff #S stated facility does not have a policy on special diets. He/she stated resident eats better if food is served all in one bowl pureed together. Confirmed facility has no documentation	S3290		

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S3290	Continued From page 10 indicating one bowl meals are resident ' s preference. Also confirmed certified staff gave resident #707 an ice cream sandwich that was not pureed. For resident #707, who received a mechanically altered diet, the operator/nurse failed to ensure the diet was prepared according to instructions from a medical care provider or licensed dietitian.	S3290		