STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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 are the result of a licensure survey conducted at the above named residential care facility located in Overland Park Kansas on 9/19/17, 9/20/17 and 9/21/17	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: KAR 26-41-202(h) The facility reported a census of 62 residents. The sample included 6 residents. Based on record review and interview for 3 (#920, 921,922) the operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement. Findings included: - Record review for resident #920 recorded an admission date of 2/10/17 with diagnoses of Dementia with Lewy body, Parkinsonism, gastroesophogeal reflux disease, osteoarthritis, urinary incontinence, sleep disorder and depression.	S3101		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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 Functional Capacity Screen (FCS) dated 9/16/17 recorded resident unable to perform the tasks of: bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. Negotiated Service Agreement (NSA) dated 9/20/17 recorded staff to assist resident with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. NSA lacked the signatures of those participating in the agreement, (responsible party). Record review for resident #921 recorded an admission date of 5/2/17 with diagnoses including: pain, peripheral vascular disease, dementia, atrial fibrillation, cardiac pacemaker, diverticulosis, dyspnea and Alzheimer's. FCS dated 5/28/17 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. NSA dated 5/28/17 recorded staff to assist resident with bathing, dressing, toileting, transfer and walk/mobility. NSA lacked the signatures of those participating in the agreement (nurse and responsible party). Record review for resident #922 recorded an admission date of 9/11/17 with diagnoses of: chronic obstructive pulmonary disease, aortic stenosis, hypertension, dysphagia, anemia, and dementia and gastroesophogeal reflux disease. FCS dated 9/9/17 recorded resident unable to perform bathing, dressing, toileting, transfer and management of medications and treatments and	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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 walk/mobility. NSA dated 9/11/17 recorded resident to receive assistance with perform bathing, dressing, toileting, transfer and management of medications and treatments and assistance with walk/mobility. NSA lacked the signatures of those participating in the agreement (nurse and responsible party). Interview on 9/20/17 at 1:07pm with licensed nurse B and operator A confirmed lack of signatures of those participating in the development of the NSAs. For residents #920, 921 and 922 the operator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement.	S3101		
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)	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3155	Continued From page 3	S3155		

The facility reported a census of 23 residents. The sample included 3 residents. Based on record review, observation and interview for 2 (#920, #921) sampled residents, requiring health care services, the operator failed to 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.

Findings included:

- Record review for resident #920 recorded an admission date of 2/10/17 with diagnoses of Dementia with Lewy body, Parkinsonism, gastroesophogeal reflux disease, osteoarthritis, urinary incontinence, sleep disorder and depression.

Functional Capacity Screen (FCS) dated 9/16/17 recorded resident unable to perform the tasks of: bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments.

Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 9/20/17 recorded staff to assist resident with bathing, dressing, toileting, transfer, and management of medications and treatments.

Nurse's note dated 8/8/17 recorded: "Hospice provided Pommel cushion for resident wheelchair."

HCSP lacked interventions for use of a pommel cushion (cushion designed to prevent sliding) and interventions for resident's need for assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3155	Continued From page 4 with walk/mobility. Interview on 9/20/17 at 1:45pm with licensed nurse B confirmed resident uses a pommel cushion in his/her wheelchair and resident is unable to ambulate and required assistance with mobility in a wheelchair. Record review for resident #921 recorded an admission date of 5/2/17 with diagnoses including: pain, peripheral vascular disease, dementia, atrial fibrillation, cardiac pacemaker, diverticulosis, dyspnea and Alzheimer's. FCS dated 5/28/17 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. NSA/HCSP dated 5/28/17 recorded staff to assist resident with bathing, dressing, toileting, transfer and walk/mobility. September 2017 medication administration record recorded staff administration of 14 medications and 1 treatment. Observation on 9/20/17 at 12:35 in resident's room revealed 2 fall mats beside resident's bed and bed bolsters (used to prevent rolling out of bed) on both sides of resident's mattress. NSA/HCSP lacked entries for management of medications and treatments and use of fall mats and bed bolsters. Interview on 9/20/17 at 1:25pm with licensed nurse B confirmed resident received staff assistance with medications and treatments and NSA/HCSP lacked entries for management of	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3155	Continued From page 5 medications and treatments and use of fall mats and bed bolsters. For 2 (#920, #921) sampled residents, requiring health care services, the operator failed to 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.	S3155		
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. The sample included 3 residents. Based on record review and interview, the operator failed to ensure 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 as evidenced by review of resident records for residents (#920, #921 and #922) who required health care services. Findings included:	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3165	Continued From page 6 - Record review for resident #920 recorded an admission date of 2/10/17 with diagnoses of Dementia with Lewy body, Parkinsonism, gastroesophogeal reflux disease, osteoarthritis, urinary incontinence, sleep disorder and depression. Functional Capacity Screen (FCS) dated 9/16/17 recorded resident unable to perform the tasks of: bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. Negotiated Service Agreement (NSA) dated 9/20/17 recorded staff to assist resident with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. Record review for resident #921 recorded an admission date of 5/2/17 with diagnoses including: pain, peripheral vascular disease, dementia, atrial fibrillation, cardiac pacemaker, diverticulosis, dyspnea and Alzheimer's. FCS dated 5/28/17 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. NSA dated 5/28/17 recorded staff to assist resident with bathing, dressing, toileting, transfer and walk/mobility. Record review for resident #922 recorded an admission date of 9/11/17 with diagnoses of: chronic obstructive pulmonary disease, aortic stenosis, hypertension, dysphagia, anemia, and dementia and gastroesophogeal reflux disease. FCS dated 9/9/17 recorded resident unable to	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3165	Continued From page 7 perform bathing, dressing, toileting, transfer and management of medications and treatments and assistance with walk/mobility. NSA dated 9/11/17 recorded resident to receive assistance with perform bathing, dressing, toileting, transfer and management of medications and treatments and assistance with walk/mobility. All 3 NSAs lacked the name of the licensed nurse responsible for the implementation and supervision of the health care service plan. All residents listed on the current resident roster required health care services. Interview on 9/20/17 at 2:13pm with facility operator A confirmed all NSAs lacked name of the licensed nurse responsible for the implementation and supervision of the health care service plans. The operator failed to ensure the negotiated service agreement for all residents contained 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 as evidenced by review of resident records for residents (#920, #921 and #922) who required health care services.	S3165		
S3200 SS=E	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	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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 8 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 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: KAR 26-41-205(d) The facility reported a census of 23 residents. The sample included 3 residents. Based on record review and interview for 2 residents (#920 and #921), the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations. Findings included: - Record review for resident #920 recorded an admission date of 2/10/17 with diagnoses of Dementia with Lewy body, Parkinsonism, gastroesophogeal reflux disease, osteoarthritis,	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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 9 urinary incontinence, sleep disorder and depression. Functional Capacity Screen (FCS) dated 9/16/17 recorded resident unable to perform the tasks of: management of medications and treatments. Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 9/20/17 recorded staff to assist resident management of medications and treatments. September 2017 medication administration record (MAR) recorded the following medications administered by staff starting on admission date 9/11/17 until 9/19/17. Albuterol/Atrovent (respiratory medication) nebulizer 1 vial via nebulizer QID (4 times daily) for COPD (chronic obstructive pulmonary disease). O2 (oxygen) at 4 liters continuous via nasal cannula for COPD. Signed physician admission orders dated 9/7/17 lacked orders for the nebulizer treatments and oxygen. Interview on 9/19/17 at 3:50pm with licensed nurse B confirmed admission physician orders lacked the medications and telephone orders were not obtained for the medications. Record review for resident #921 recorded an admission date of 5/2/17 with diagnoses including: pain, peripheral vascular disease, dementia, atrial fibrillation, cardiac pacemaker, diverticulosis, dyspnea and Alzheimer's.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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 10 FCS dated 5/28/17 recorded resident required assistance with management of medications and treatments. NSA/HCSP dated 5/28/17 lacked entry for facility management of medications and treatments. September 2017 MAR recorded: Zinc oxide 20 percent ointment, apply topically to reddened area of groin twice daily, scheduled to be administered at 9am and 5pm. Medication record lacked staff entries for the 5pm administration of the medication for September 1 and September 3 through14th. Interview on 9/20/17 at 1:25pm with licensed nurse B confirmed record lacked entries for administration of the medication. For residents #920 and #921 the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order, professional standards of practice and each manufacturer's recommendations.	S3200		
S3248 SS=F	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3248	Continued From page 11 background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102 (d) The census equaled 23 the sample included 3 residents. Based on interview and review of facility records, for 4 of 4 certified staff (#C, #D, #E and #F) the operator failed to ensure the employee records contained supporting documentation for criminal background checks. Findings included: - Review of personnel records on 7/19/17 for certified staff hired, lacked documentation of criminal background checks through health occupations and credentialing upon hire for the following new hire staff: Certified staff #C, hire date ; 6/20/17	S3248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3248	Continued From page 12 Certified staff #D, hire date ; 1/9/17 Certified staff #E, hire date ; 3/7/17 Certified staff #F, hire date : 6/27/17 Interview on 9/19/17 at 2:38pm, with facility operator A, confirmed all criminal background checks were conducted thru an outside agency and were not completed through health occupations and credentialing. The operator failed to ensure the employee record contained supporting documentation for criminal background checks through health occupations and credentialing.	S3248		
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. The sample included 3 residents. Based on record review and interview for 3 sampled residents (#920,921,922), the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3261	Continued From page 13	S3261		

Findings included:

- Record review for resident #920 recorded an admission date of 2/10/17 with diagnoses of Dementia with Lewy body, Parkinsonism, gastroesophogeal reflux disease, osteoarthritis, urinary incontinence, sleep disorder and depression.

Functional Capacity Screen (FCS) dated 9/16/17 recorded resident unable to perform the tasks of: bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments.

Negotiated Service Agreement/HCSP (NSA/HCSP) dated 9/20/17 recorded staff to assist resident with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments.

Nurse's notes recorded on the following dates lacked time of entry/event: 2/17/17, 3/15/17, 4/2/17, 6/2/17, 6/7/17, 6/27/17, 7/25/17, 8/2/17 and 8/8/17.

Record review for resident #921 recorded an admission date of 5/2/17 with diagnoses including: pain, peripheral vascular disease, dementia, atrial fibrillation, cardiac pacemaker, diverticulosis, dyspnea and Alzheimer's.

FCS dated 5/28/17 recorded resident required assistance with bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3261	Continued From page 14 NSA/HCSP dated 5/28/17 recorded staff to assist resident with bathing, dressing, toileting, transfer and walk/mobility. Nurse's notes recorded on the following dates lacked time of entry/event: 6/30/17, 7/10/17, 7/11/17, 7/17/17,7/17/17, 7/18/17, 7/26/17,8/16/17, 8/17/17, 8/30/17, 9/9/17, 9/13/17, 9/15/17, 9/16/17, 9/18/17 and 9/19/17. Nurse's notes dated 6/30/17, 7/17/17 and 7/24/17 recorded resident falls. Time of the falls was not recorded. Nurse's note dated 7/27/17 recorded: "Bruising noted to left buttock and upper leg, had fall on 7/24/17 ..." Record lacked description of the bruises including size and color. Record review for resident #922 recorded an admission date of 9/11/17 with diagnoses of: chronic obstructive pulmonary disease, aortic stenosis, hypertension, dysphagia, anemia, and dementia and gastroesophogeal reflux disease. FCS dated 9/9/17 recorded resident unable to perform bathing, dressing, toileting, transfer and management of medications and treatments and assistance with walk/mobility. NSA/HCSP dated 9/11/17 recorded resident to receive assistance with perform bathing, dressing, toileting, transfer and management of medications and treatments and assistance with walk/mobility. Nurse's notes dated 9/11/17 and 9/15/17 lacked time of entry/event. Interview on 9/20/17 at 1:07 with licensed B and	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

(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
S3261	Continued From page 15 operator/licensed nurse A confirmed nurse's notes lacked time of entries. They also confirmed resident #921 record lacked measurement of the bruises noted on 7/27/17. For residents #920, 921 and 922, the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.	S3261		