STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 Resurvey at the above named Assisted Living Facility in Overland Park, Kansas on 10/18/16, 10/19/16, 10/20/16, 10/24/16, and 10/25/16. Complaints #102642, #103393, #104334, #104445, #106443, and #106531 also investigated.	S 000		
S3081 SS=D	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(2) The facility census equalled 36. The sample included three Residents, with focused reviews completed on two Residents. Based on interviews, and reviews of records, for one focused review Resident (#180), the Administrator failed to ensure designated staff conducted a screening to determine Resident's functional capacity following significant change in condition upon return to the facility following hospitalization for a stroke. Findings included:	S3081		

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
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3081	Continued From page 1 - Review of record revealed #180 admitted to facility 10/27/11 with diagnoses of Cognitive impairment, Chronic back pain, Congestive heart failure, Benign prostatic hypertrophy, Osteoarthritis, Hyperlipidemia, and Hypothyroidism. The current 7/08/16 FCS (functional capacity screen) assessed #180 in need of supervision (1) with bathing, dressing, toileting, transfers; independent (0) with mobility, eating; unable to perform (3) medication and treatment management; with bladder incontinence; with impaired short term memory, long term memory, memory recall, and decision making; with falls/unsteadiness; used walker and wheelchair. The current 7/08/16 NSA (negotiated service agreement) and Health Care Service Plan documented #180 to receive services to address needs identified on 7/08/16 FCS. Nurse's Notes (NN) documented: 7/12/16 - 1105 am - on call physician called 7 30 am to send Resident to emergency room... #180 presented with Right side weakness upper and lower extremities... face drooping Right side... hand grip right weak... 7/14/16 - 4:00 pm - Re-admitted to facility... has Right sided weakness and is a two person assist... has dysphagia... family wants #180 on a Mechanical soft diet rather that a Puree diet as hospital specified... #180 on Oxygen at 4 Liter... is very anxious... PRN (as needed) Lorazepam given at 1730... catheter in place... 7/14/16 (should be 7/15/16)- 1 a.m. - Resident	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3081	Continued From page 2 was found on floor next to bed laying prone... Resident struggling to sit up and when helped onto side noted to have a bloody nose and disoriented... transported to hospital... (The nurses notes lacked additional entries. The medical record lacked a significant change FCS for #180 completed upon return from hospital. On 10/20/16 at 3:00pm, Administrator #K, Health Care Coordinator (HCC) #F, and Regional Nurse #M confirmed #180 returned to facility on 7/14/16... confirmed facility staff did not go to hospital to assess #180 prior to return... confirmed no additional FCS available and no changes had been made to the 7/08/16 FCS. The Administrator failed to ensure designated staff conducted a screening to determine #180's functional capacity following any significant change in condition.	S3081		
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)	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 3 The census equalled 36 the sample included three Residents and two focused reviews completed. Based on review of record and interview, for two of three sampled (#189 and #185), the Administrator failed to ensure each individual involved in the development of the negotiated service agreement (NSA) signed the agreement. Findings included: - Review of record revealed #189 admitted to facility 9/26/16 with diagnoses of Dementia, Seborrhetic dermatitis, Encephalopathy, and Alcoholism. The current functional capacity screen (FCS) of 9/26/16 (not in the record at time of review but provided from Health Care Coordinator's (HCC) office) assessed #189 in need of Supervision with bathing, and unable to perform medication and treatment management. The current NSA of 9/26/16 (also not in chart at time of review but provided by HCC) documented facility staff to assist with medications, treatments, toileting, bathing, dressing, and hygiene, eating, orientation, behavior management, and socialization. The NSA lacked any signatures. On 10/18/16 at 5:29pm, Health Care Coordinator (HCC) #F confirmed the medical record lacked an NSA. HCC #F left to search for NSA in office, and returned with NSA. HCC #F confirmed the NSA lacked any signatures. - Review of record revealed #185 admitted to facility 8/16/16 with diagnoses of Fronto-temporal	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 4 dementia, Arthritis, Major depressive disorder, and Schizophrenia. The current functional capacity screen (FCS) of 8/16/16 (not in the record at time of review but provided from Health Care Coordinator's (HCC) office) assessed #185 unable to perform medication and treatment management. The current NSA of 8/16/16 (also not in chart at time of review but provided by HCC) documented facility staff to provide health monitoring, nursing intervention, supplies/service coordination, medication and treatment management, and eating. The NSA lacked any signatures. On 10/18/16 at 4:51 HCC #F unable to locate the NSA... did locate and provide at 5:00pm... HCC #F confirmed the NSA not signed by anyone. The Administrator failed to ensure each individual involved in the development of the NSA's for #185 and #189 signed the agreement.	S3101		
S3155 SS=G	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	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 by: KAR 26-41-204(a) The census equalled 36. The sample included three Residents and 2 focused review residents. Based on interviews and record reviews, for one focused review (#180) the Administrator failed to ensure a licensed nurse provided or coordinated the provision of health care services to address the health care needs of a cognitively impaired Resident newly diagnosed with stroke, right sided weakness, and dysphagia upon his/her return from the hospital. Resident #180 fell approximately 10 hours after returning to the facility and suffered a subacute left cerebral hemorrhagic infarct at the location of his/her previous CVA (cerebral vascular accident) due to the fall. Findings included: - Review of record revealed #180 admitted to facility 10/27/11 with diagnoses of Cognitive impairment, Chronic back pain, Congestive heart failure, Benign prostatic hypertrophy, Osteoarthritis, Hyperlipidemia, and Hypothyroidism. The current FCS (functional capacity screen) dated 7/08/16 assessed #180 required supervision with toileting, and transfers; independent with mobility; unable to perform medication and treatment management; experienced impaired short term memory, long term memory, memory recall, and decision making; and falls/unsteadiness identified as a current or recent problem. Note: the functional capacity screen was not updated following the significant change in	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 6 condition. The current Health Care Service Plan (HSP) dated 7/08/16 documented staff to provide assistance with transfers and ambulation, resident used a wheelchair that staff pushed from place to place; alert and oriented to person/place/time. Resident spoke with strong, clear voice and able to make needs known. Resident was high risk for falls and to be encouraged to use call light for assistance. The HSP lacked revision following his/her hospitalization for a stroke. The re-admission transfer sheet from hospital dated 7/14/16 documented "Stroke"; "Please arrange Home Health; Activity/Weight Bearing "as tolerated." The HSP lacked Oxygen, Home Health, two person transfers, dysphagia, and interventions to address anxiety besides medication. Nurses ' notes documented: 7/12/16 - 11:05 a.m. - on call physician called 7:30 a.m. to send Resident to emergency room... #180 presented with Right side weakness upper and lower extremities... face drooping Right side... hand grip right weak. 7/14/16 - 4 00 p.m. - Re-admitted to facility... has Right sided weakness and is a two person assist... has dysphagia... #180 on Oxygen at 4 Liter... is very anxious... PRN (as needed) Lorazepam given at 1730... catheter in place 7/14/16(should be 7/15/16) - 1:00 a.m. - Resident was found on floor next to bed laying prone(flat	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 7	S3155		

on back)... Resident struggling to sit up and when helped onto side noted to have a bloody nose and disoriented... transported to hospital.

The HSP lacked interventions to address resident #180 ' s right sided weakness, need for two-person assist with transfers, dysphagia, and anxious behavior.

Statements written as part of investigation after Resident found on floor 7/15/16 at 1:00 am recorded the following::

Licensed Practical Nurse (LPN) #I: Dated 7/14/16 did not include the name of the resident and referred to him/her as the patient. The statement recorded the resident ' s return to the facility and stated in part " patient was taken to the dining room and pt was so anxious, trying to stand up and cannot stay still in his/her wheelchair. On call doctor was called and prn antianxiety medication and scheduled medication was ordered. . .patient got his/her scheduled medication and was under staff supervision in the living room. Patient was later on transferred to the recliner in the living room and was still agitated. Patient finally calmed down and the [staff] took him /her room. . .staff stayed in the room with patient and patient fell asleep. I went to check on patient and found the [staff] transferring him/her to the wheelchair stating that he/she is anxious and cannot stay in the room. Patient was brought to the living room and assisted to the recliner. Patient is still anxious, trying to stand up and walk. Patient stayed in the living room for a while under staff supervision but will not calm down. PRN (as needed) Lorazepam (antianxiety medication) was given. Patient slept on in the recliner. Finally patient was taken to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 8	S3155		

his/her room when he was taken to bed. Patient was asleep by the time this nurse checked on him,/her at 11 p.m. "

LPN #O: "On 7/14/16 about 1:00 a.m. aide assigned to #180 reported he/she was laying on the floor in room beside his/her bed.. . #180 was noted to have a bloody nose already dried blood. There was no blood on the floor. . EMS was notified and arrived shortly to transport resident to [hospital]. . .#180 had been las seen in bed at about 11 p.m. during change over rounds. "

LPN #Q: " . . .the aide stated that this resident had become restless again and tried to ambulate unassisted while in apartment.. he/she was moving back and forth with his/her wheelchair. He/she was trying to independently transfer self from his/her wheelchair to a dining room chair. I was doing paperwork. Staff intervened, assisted him to a recline in the living room. . .noted resident to still be fidgeting in the chair and looking/feeling for something on the side of the recliner and trying to get up. Staff tried to redirect until resident became frustrated to where he/she began yelling at staff. Staff informed resident that they would assist him/her to bed after they did medication count. The staff returned to the living room after a while to inform this nurse that as soon as they put pajamas on the resident and assisted him/her to bed, he/she was fast asleep. No further incidents noted or reported. "

On 10/20/16 at 3:00pm, Administrator #K, Health Care Coordinator (HCC) #F, and Regional Nurse #M confirmed #180 returned to facility on 7/14/16, confirmed facility staff did not go to hospital to assess #180 prior to return and confirmed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 9 changes were made to FCS or NSA or HSP. Consultation note documented a computerized axial tomogram (CT) scan [on 7/15/16] showed a subacute left cerebral hemorrhagic infarct (brain bleed) at the location of his/her previous CVA (stroke). And the Neurology consultation notes dated 7/15/16 documented resident #180 with " recent CVA now with hemorrhagic conversion due to fall. " For resident #180, the administrator failed to ensure the licensed nurse provided or coordinately the provision of health care services to address this resident ' s inability to transfer without the assistance of two staff and anxious behavior. Resident #180 was found on the floor two hours after the last visual check with facial injury and transferred to the hospital where he/she admitted with a brain bleed at the site of the previous stroke due to the fall.	S3155		
S3165 SS=D	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 census equalled 36 the sample included three Residents and two focused reviews completed. Based interviews and reviews of records, for one of three sampled (#187) and for	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 10	S3165		

two of two focused (#180 and #182), the Administrator failed to ensure the negotiated service agreement (NSA) contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan (HSP).

Findings included:

- Review of record revealed #180 admitted to facility 10/27/11 with diagnoses of Cognitive impairment, Chronic back pain, Congestive heart failure, Benign prostatic hypertrophy, Osteoarthritis, Hyperlipidemia, and Hypothyroidism.

The current 7/08/16 FCS (functional capacity screen) assessed #180 in need of supervision with bathing, dressing, toileting, transfers; unable to perform medication and treatment management; with bladder incontinence; with impaired short term memory, long term memory, memory recall, and decision making; with falls/unsteadiness; used walker and wheelchair.

The current 7/08/16 NSA (negotiated service agreement) and Health Care Service Plan documented #180 to receive services to address needs identified on 7/08/16 FCS.
The NSA contained the statement "Director of Nursing to implement and supervise Health Service Plans."
The NSA lacked the name of the nurse responsible for the implementation and supervision of the HSP.

- Review of record revealed #182 admitted to facility 7/20/15 with diagnoses not specified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 11 The current Functional Capacity Screen (FCS) of 7/20/15 assessed #182 in need of physical assistance with bathing, dressing, medication and treatment management; in need of supervision with toileting; Incontinent of bladder; with short term, long term, memory/recall and decision making impairments. The current 7/20/15 Negotiated Service Agreement (NSA) documented facility to provide services to meet the needs identified in the FCS. The NSA contained the statement "Director of Nursing to implement and supervise Health Service Plans." The NSA lacked the name of the nurse responsible for the implementation and supervision of the HSP. - Review of record revealed #187 admitted to facility 5/01/16 with diagnoses of Dementia-Alzheimer's type, Anxiety, Hypothyroidism, Hypertension, Depression, Organic brain syndrome, and Degenerative disc. The current Functional Capacity Screen (FCS) of 7/08/16 assessed #187 unable to perform bathing, dressing, toileting, transfers, mobility, medication and treatment management; Incontinent of bladder; with short term, long term, memory/recall and decision making impairments; with falls/unsteadiness and used wheelchair. The current 7/08/16 Negotiated Service Agreement (NSA) documented facility to provide services to meet the needs identified in the FCS. The NSA contained the statement "Director of Nursing to implement and supervise Health Service Plans." The NSA lacked the name of the nurse	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 12 responsible for the implementation and supervision of the HSP. On 10/19/16 at 5:50pm Administrator #K confirmed the name of the nurse responsible not documented on these NSA's. The Administrator failed to ensure the NSA's for #180, #182, and #187 contained the name of the licensed nurse responsible for the implementation and supervision of the HSP.	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 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)(1-2)	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 13	S3200		

The facility census equalled 36. The sample included three Residents, and focused reviews completed on two Residents. The facility identified all Residents as receiving medication management. Based on interviews and reviews of record, for one focused review Resident (#180), the Administrator failed to ensure all medications administered in accordance with medical provider's written orders and in accordance with professional standards.

Findings included:

- Review of record revealed #180 admitted to facility 10/27/11 with diagnoses of Cognitive impairment, Chronic back pain, Congestive heart failure, Benign prostatic hypertrophy, Osteoarthritis, Hyperlipidemia, and Hypothyroidism.

The current 7/08/16 FCS (functional capacity screen) assessed #180 in need of medication and treatment management (3) unable to perform.

The current 7/08/16 NSA (negotiated service agreement) documented #180 to receive medication management by facility.

Review of the MAR (medication administration record) identified by the facility as July 2016 revealed #180 did not receive medications as ordered, and medications administered not documented in accordance with professional standards of practice.

According to Nurse's Notes, #180 admitted to hospital on 7/12/16, re-admitted to facility on 7/14/16. The July 2016 MAR contained medication orders faxed to facility from hospital at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 14 3:31pm on 7/14/16. These medication orders lacked a medical provider's signature in accordance with professional standards. Clopidrogel (blood thinner) 75mg (milligrams) daily at 0900 Potassium Chloride (mineral supplement) 10 mEq (milliequivalent) daily at 0900 Finasteride (to treat urinary retention) 5mg daily at 0900 Folic acid (supplement) 0.8mg daily at 0900 Furosemide (diuretic) 20mg daily at 0900 Levothyroxine (to treat hypothyroidism) 75 mcg (micrograms) daily at 0900 Lorazepam (to treat anxiety) 0.5mg one tab twice daily for anxiety Lovastatin (to treat high cholesterol)40mg at bedtime Melatonin (sleep aide) 3mg at bedtime Metoprolol tartrate (to treat high blood pressure) 25mg twice a day Naproxen (anti-inflammatory) 250mg twice a day Tamsulosin (to treat urinary retention) 0.4mg twice a day Benzonatate (to treat cough) "not specified" (this medication lacked any directions for administration) The July 2016 MAR lacked: 1) Completion of the spaces on the form for room number, sex of resident, birth date, allergies, physician, and diagnosis 2) The identifying Month and Year in accordance with professional standards 3) The administration of scheduled Naproxen at 5:00pm as stated in a facility investigation of Resident's fall 4) The administration, refusal, unavailability, or holding of all medications as ordered for 7/14/16 at 1800 and HS (bedtime) - space for notation of administration of all medications remained blank	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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 15 5) The administration of an 11:00pm dose of Lorazepam on 7/14/16 as stated in a facility investigation of Resident's fall, and as noted on Controlled Substances Proof of Use form This July 2016 MAR documented a 7/14/16, 7:00 pm administration of a dose of Lorazepam 0.5 mg 1 tab every 24 hours as needed for anxiety, on the MAR in the 7/01/16 through 7/03/16 date box by writing 7/16, 1900 (7 pm.) , and [initials of staff administering the medication] . The Controlled Substances Proof of Use form, initiated on 7/08/16, lacked documentation of the Lorazepam dose administered at 7:00 p.m. on 7/14/16, but contained the 11:00 pm dose. Documentation of phone order for Lorazepam 0.5mg twice daily and also PRN (as needed) lacked the date phone order written. On 10/19/16 at 5:05pm, Licensed Practical Nurse #I confirmed the Lorazepam doses not documented in accordance with professional standards... confirmed reviewed MAR pages were July 2016... confirmed the phone order for Lorazepam lacked the date medical provider gave the order. The Administrator failed to ensure all medications administered to #180 in accordance with medical provider's written orders and in accordance with professional standards.	S3200		
S3250 SS=E	26-41-105 (a) Resident Records a) The administrator or operator of each assisted living facility or residential health care facility shall	S3250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3250	Continued From page 16 ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: KAR 26-41-105(a) The facility census equalled 36. The sample included three Residents, and two focused review residents. Based on interviews and reviews of record, for two of two focused reviews (#180 and #182), the Administrator failed to ensure the maintenance of a record for each Resident in accordance with accepted professional standards and practices. Findings included: - Review of record revealed #182 admitted to facility 7/20/15 with diagnoses not specified. The current Functional Capacity Screen (FCS) of 7/20/15 assessed #182 in need of physical assistance with Bathing, Dressing, Medication and Treatment management; in need of supervision with toileting; independent with	S3250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3250	Continued From page 17	S3250		

transfers, mobility, and eating; Incontinent of bladder; with short term, long term, memory/recall and decision making impairments.

The current 7/20/15 Negotiated Service Agreement (NSA) documented facility to provide services to meet these needs.

Review of "CNA (certified nurse aide) Skin Assessment Shower Forms" revealed "Refused" on 8/13/16, 8/09/16, 7/16/16, 7/12/16, 7/09/16, and 7/02/16.
Medical Record Nurse's Notes on these dates lacked assessment of Resident by licensed nurse for causal factors of
refusals and lacked documentation of interventions developed or attempted in order to provide services agreed upon in NSA.

Review of facility discharge list identified #182 leaving facility on 8/13/16.
Medical Record Nurse's Notes lacked documentation of resident #182 ' s date, time and reason for discharge. Medical Record Nurse's Notes lacked any entries after 7/28/16.

For resident #182, the administrator failed to ensure the maintenance of a record to meet professional standards and practices for documentation.

On 10/20/16 at 3:00pm, Administrator #K, Health Care Coordinator (HCC) #F, and Regional Nurse #M confirmed Resident no longer resided at facility and confirmed the record lacked documentation of the discharge.

The Administrator failed to ensure the maintenance of a record for #182 in accordance with accepted professional standards and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3250	Continued From page 18 practices. - Review of record revealed #180 admitted to facility 10/27/11 with diagnoses of Cognitive impairment, Chronic back pain, Congestive heart failure, Benign prostatic hypertrophy, Osteoarthritis, Hyperlipidemia, and Hypothyroidism. The current 7/08/16 Functional Capacity Screen (FCS) assessed #180 in need of supervision with bathing, dressing, toileting, and transfers; independent with mobility and eating; unable to perform medication and treatment management; with bladder incontinence; with impaired short term memory, long term memory, memory recall, and decision making; with falls/unsteadiness; used walker and wheelchair. The current 7/08/16 Negotiated Service Agreement (NSA) documented #180 to receive services for these identified needs. Nurse's Note of the record, (7/15/16 at 0100) noted #180 transported to hospital with bloody nose and possible head injury after a non-witnessed fall. Review of facility discharge list identified #180 leaving facility on 7/25/16. Review of the facility investigation completed regarding the 7/15/16 fall revealed multiple symptoms of anxiety and restlessness, the administration of medications, family requests for care, monitoring and moving Resident to different locations in facility. Medical Record Nurse's Notes lacked pertinent information occurring between 1600 on 7/14/16 and 0100 on 7/15/16.	S3250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3250	Continued From page 19 Medical Record Nurse's Notes lacked any documentation to indicate Resident's departure or that Resident no longer resided at facility. Medical Record Nurse's Notes lacked any entries after 7/15/16. On 10/20/16 at 3:00pm, Administrator #K, Health Care Coordinator (HCC) #F, and Regional Nurse #M confirmed Nurse's Notes lacked information included in the facility investigation, pertinent to the evening of re-admission to facility, fall, and subsequent return to the hospital on 7/15/16... confirmed #180 no longer resided at facility... stated we stopped billing but we would not necessarily put an entry in the record. For Residents #180 and #182, the Administrator failed to ensure the maintenance of a record in accordance with accepted professional standards and practices.	S3250		
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	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3280	Continued From page 20 secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d) The facility census equalled 36. The sample included three Residents, and focused reviews completed on two Residents. The facility identified 105 employees hired since the last Resurvey. Based on interviews and reviews of records, the Administrator failed to ensure disaster and emergency preparedness by conducting quarterly reviews of the facility's emergency management plan with employees and Residents, and; the Administrator failed to ensure an emergency evacuation drill conducted at least annually with staff and Residents. Findings included: - On 10/19/16 at 5:55pm, Administrator #K stated we have not completed Resident emergency reviews quarterly. Administrator #K confirmed not able to find dates of "full evacuation" drills conducted since the last Resurvey. Administrator #K stated we review the entire manual with all employees at time of hire, but after that we use an online system of inservice courses... topics of the courses (Workplace Emergencies and Natural Disasters: An Overview; and Fire Safety: The Basics) present an "overview" of important procedures for emergencies... Administrator #K confirmed the online courses were not a specific review of the facility's emergency plan... the overview did not	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046045	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS MEMORY CARE COMMUNIT	12340 QUIVIRA RD 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
S3280	Continued From page 21 present facility specific policies and procedures. Administrator #K provided a course status printout that included percentages of completion, timeliness, and overall "Total Compliance." The total compliance rate for "All Courses" at 15.19%. This format did not identify names of staff or dates completed. For all residents and employees, the Administrator failed to ensure reviews of the facility's emergency management plan completed quarterly with both employees and Residents and the Administrator failed to ensure an emergency evacuation drill conducted at least annually with staff and Residents.	S3280		