STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046071	A. BUILDING: _____ B. WING _____	09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	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 citation represents the finding of an abbreviated survey with complaint investigation 92009 at the above named assisted living facility conducted on 9-29-15 and 9-30-15.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

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

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S3028	Continued From page 1 KAR 26-41-101(f)(3)(A) The facility reported a census of 90 residents. The sample included 6 residents. Based on record review and interview for 1 (#4) of 6 sampled residents, the administrator failed to ensure each allegation of abuse, neglect or exploitation shall be reported to the department within 24 hours and an investigation shall be started when the administrator receives notification of an alleged violation. Findings included: - Record review for resident #4 revealed admission on 10-19-14 with diagnoses Cervical Spinal Stenosis, Diabetes Mellitus II, Depression, Hyperlipidemia, Muscle Spasms, Anxiety, Atrial Fibrillation, Dementia, Gastroesophageal Reflux Disorder and Glaucoma. The functional capacity screen dated 4-23-15 recorded resident required physical assistance with bathing, dressing, toileting, transfers and walking/mobility; independent with eating; unable to perform management of treatments. Occasionally incontinent of bladder. Cognition: problems with decision-making. Problems: impaired decision-making. Uses wheelchair. The negotiated service agreement dated 4-23-15 recorded services for mobility, transferring, grooming, bathing, assistance to bathroom, dressing, dining and nutrition and medication services. Documentation from facility Progress Notes revealed: Written on 8-31-15 at 2:33 pm: "This morning around 10:30 am this writer was notified that	S3028		

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S3028	Continued From page 2	S3028		

resident was not normal self. This writer immediately went to assess resident and he/she was unable to tell what was wrong, which was not his/her norm...kept grabbing right side of chest and grimacing and lifting up right leg and right arm was shaking. I asked if chest was hurting and all he/she could do was nod yes. This writer immediately called 911. Paramedics came to assess resident. While they were hooking up their testing equipment (resident #4) started having a seizure and was leaning to right side. (Resident) was transported immediately to the hospital.." Signed by licensed staff A.
[Further documentation in progress notes stated on 9-11-15 that resident passed away at hospice.]

Interview on 9-29-15 at 3:30 pm with administrator stated when resident #4's family member was moving resident's personal belongings out, the family member asked if resident had fallen. Stated the hospice had mentioned to them that resident had bruising...doesn't remember where, but thinks it was a hip. Stated "it was a pretty big size bruise." Per administrator's written statement, "...(resident #4) left (facility) on 8-31-15 then went to hospital where he/she was admitted. After at least 5 days he/she was then transported to hospice. I explained to (family member) that our staff was not aware of any falls or any incidents prior to leaving for (the hospital) that would have caused a large bruise on his/her hip. (The family member) acknowledged my response and said if I did find anything out to let them know. This writer has interviewed staff that worked consistently with (resident #4) and there were no incidents in the month of August that could have explained the bruising to his/her hip." Regarding whether administrator obtained written statements from staff during investigation,

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S3028	Continued From page 3 administrator stated "I think I did, if not, I can go get them." Facility failed to provide written staff statements and failed to provide documentation of report to the department. For resident #4, the administrator failed to report an allegation of abuse or neglect to the department after a family member reported bruising noticed by an outside provider and further failed to investigate for a possible cause of the bruising.	S3028		