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 _____	08/10/2015

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 citations represent the findings of an abbreviated survey and complaint investigation 90027 conducted at the above named assisted living facility on 8-5-15, 8-6-15 and 8-10-15.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 88 residents. The sample included 7 residents. Based on record review and interview for 1(#1) of 7 sampled residents receiving a mechanically altered diet, the administrator failed to ensure the resident was not be subjected to neglect when facility staff failed to provide mechanically altered meat as ordered for this resident who had a history of pocketing food, choking, and aspiration pneumonia. This failure placed Resident #1 in immediate jeopardy for harm, injury or death. Resident #1 choked, aspirated and passed away at the hospital a few hours later. Findings included:	S3026		

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

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S3026	Continued From page 1	S3026		

Facility instructions for Mechanical Soft kept in a folder on the special care unit and in the kitchen stated the following:
" Least restrictive dysphagia diet, consisting of foods that are easy to chew with varying textures. Meat is ground or chopped to appropriate consistency, and regular consistency starches and vegetables are served. Sauce of choice is offered at every meal, breads are served with a spread, and cookies and cakes are moist in consistency. The following foods are restricted: corn, fried potatoes and potatoes with peels, toast, pineapple, raisins and dried fruits, raw fruits, and vegetables and nuts. "
" Mechanically Altered/Dysphagia Diets: Mechanical Soft Diet (Level 3) Meats, poultry and fish must be very tender and shredded, ground or chopped into less than or equal to ½ inch pieces and well moistened with sauce, gravy or broth ... "

- Record review for resident #1 revealed admission to the special care unit of the facility on 4-3-15 with diagnoses that included Dementia, History of Stroke, Peripheral Neuropathy, Depression, and Anxiety.

The functional capacity screen (FCS) dated 4-7-15 recorded resident required physical assistance with walking/mobility and supervision of eating; experienced impaired short term memory, long term memory, memory/recall and decision-making and identified impaired decision-making as a current or recent problem.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 4-7-15 recorded the following services:
Diet Restrictions: 4-24-15 Mechanical Soft; 4-25-15 Please Chopped up foods.
Dining and Nutrition: Level of Assistance: Step

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S3026	Continued From page 2	S3026		

by step cueing. Resident is cueing assist with diet. Team members will offer cues to eat when resident is not eating on own. 4-25-15 Chopped up food Mechanical Soft diet. 3 meals per day, prefers full portions.

The NSA/HCSP lacked interventions to address resident #1 ' s pocketing of food.

Physician ' s orders:
4-21-15: " Change diet to Mechanical Soft. "
5-28-15: " Hospice evaluation and treatment. "

Hospice Skilled Nursing Notes:
6-1-15: " Patient just ate lunch, ate 25% of the meal and family states he/she ate all his/her breakfast. Patient needs to be monitored through meals for feeding assistance and is a high risk for aspiration, oral care to be provided after each meal and check patient occasionally while he/she is eating to monitor for pocketing food ... "
6-4-15: " ...Lungs are clear, does have a history of aspiration pneumonia, and is on a mechanical soft diet and needs to be monitored for pocketing food, needs assist with meals and drinks ...coordinated care with (administrative nurse C) and (family members)

Progress Notes:
8-3-15 at 12:03 pm [note incident occurred at approximately 8:15 am]: " This writer was called to the 3rd floor. A team member called and stated (resident #1) was choking. I was in the Wellness Office on the second floor. I got to the elevator and (staff member) was on the elevator and (certified staff H) stated Resident was choking. We both went to the 3rd floor Kitchen. Resident was sitting in his/her wheelchair at the kitchen table. His/her color was pale and resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3026	Continued From page 3	S3026		

was gasping for air. I said to call 911 and was told (certified staff I) was calling 911. I ask if the Heimlich was done and was told yes with no results. . . . First responder arrived, " I then went to Wellness office as resident ' s spouse was there waiting for me as we were having a conversation prior to this. I explained that resident had choked on his/her breakfast and he/she went to the 3rd floor.. . . . " Signed by licensed staff D.

8-3-15 at 12:07 pm: " Call to hospital for update on resident who was admitted with Acute Aspiration and Respiratory Distress. Resident was being moved from the emergency room to intensive care unit. Family was with him/her. " Signed by licensed staff D.

8-3-15 at 8:56 pm: Administrative staff B received a message from resident ' s family around 3:30 pm that resident had passed. " Signed by administrative staff B.

Interview on 8-5-15 at 11:55 am with administrative staff A stated when resident ate, he/she " shoveled " food into his/her mouth continuously until mouth was full.

Interview on 8-5-15 at 12:50 pm with certified staff F stated resident used big handled spoons and forks to eat with and fed self. For two weeks prior to incident, noticed resident was pocketing food in his/her mouth and staff would have to cue him/her to swallow. Stated resident usually ate in the kitchen for closer monitoring and if he/she was disruptive and combative, they had him/her eat in the activity room but still within view of staff. Stated on 8-3-15, resident ' s family member had spent the night previously and was observed standing in the sitting area next to the kitchen.

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	N046071	A. BUILDING: _____ B. WING _____	08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3026	Continued From page 4 Stated everyone else had eaten already on the morning on 8-3-15. Confirmed he/she placed resident ' s plate in the microwave to reheat, but did not know who served the plate. Confirmed the ham was not chopped up and but was cut into " quarter-size " pieces or " maybe a little larger. " Stated there were 2-3 pieces of ham and some scrambled eggs left on resident ' s plate along with the entire pancake. Interviews on 8-5-15 and 8-6-15 with certified staff G stated resident usually eats a later breakfast because he/she gets up later per family ' s and resident ' s preferences. Confirmed resident " had trouble swallowing even with medications crushed and placed in applesauce. " Further confirmed resident would sometimes pocket his/her medications, not swallow and the medication along with the applesauce would have to be removed from the resident ' s mouth. When asked the procedure if they received food that has not been properly prepared, stated if the kitchen does not send up ground meat, we serve something else and leave the meat off " or call the kitchen and they make the ground food and we have to go down and get it. " Interview on 8-5-15 at 1:15 pm with certified staff H stated he/she was told by the family that " he/she will eat and eat and eat and look like a chipmunk (full cheeks) and they ' ll slowly go down (his/her cheeks). Stated preparation of resident ' s plate varies ...most meats are cut up in the kitchen, " but if not, we cut it up. " Confirmed the kitchen does not always send up chopped up meats for the mechanical soft diet, but all staff know to cut up the meat. Interview on 8-5-15 at 1:47 pm with dietary staff J	S3026		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3026	Continued From page 5	S3026		

stated the procedure for the kitchen staff is to check the diet book to see what needs to be mechanicalized. Meats are run through the Robot Coupe (food processor) for everyone on a Mechanical Soft diet. " Normally, those on a mechanical soft diet receive sausage. " Stated on 8-3-15 the facility was out of sausage and a staff member called him/her to ask what to substitute for resident #1. He/she told the staff to substitute ham. Confirmed the dietary staff failed to run the ham through the food processor prior to sending it to the resident ' s floor and stated " normally they ' ll call back down if it ' s not right. " " The only meat we send up mechanicalized is sausage. " Further confirmed ham cut up into " quarter-size " pieces was not compliant with the diet instructions for a mechanical soft diet.

Confidential Interview on 8-6-15 stated food for all residents on mechanical soft diets was delivered to the floor with the rest of the meals and certified staff plated the meals for the residents. Further stated sometimes will have to call down to the kitchen if they didn ' t send up mechanicalized food and " if we can ' t get hold of someone, we just cut it up and serve it the best way we can. "

Written statement from certified staff I stated: " I was working day shift 8-3-15 at 8:15 am when I witnessed resident having trouble digesting his/her food. I quickly asked (resident) if he/she was okay, I seen him/her choking so I told a fellow co-worker to get medication aide and nurse. Coordinator said call 911. I grabbed a cup for resident to spit out what ' s in his/her mouth. He/She spit eggs out and ham. Nurse came, medication aide and coordinator helped. We tried to perform Heimlich but couldn ' t get food out. He/she did spit out some, then I called 911 ...the ham he/she was choking on was half

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	N046071	A. BUILDING: _____ B. WING _____	08/10/2015

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SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3026	Continued From page 6 quarter size when he/she spit it out ... " Interview on 8-10-15 at 11:10 am with certified staff I stated resident ' s family member was in the kitchen with him/her while resident was eating, unknown as to whether family member standing across the room or seated next to resident. Certified staff F was putting away dishes. Confirmed staff " always had a problem, always had to tell (resident) to spit stuff out " because resident shoveled food into mouth. Stated other residents on mechanical soft diets that morning got ham or bacon. Resident #1 was unable to eat the bacon so was given the ham. Written statement provided on 8-6-15 at 11:15 am by administrative staff A stated: " On Monday, August 3, 2015 at approximately 8:50 am, this writer was notified by administrative nurse C that we were sending resident #1, a confused resident at (the facility) to the hospital due to difficulty in breathing. Upon investigation it was determined that resident #1 was choking on his/her breakfast. He/she was served scrambled eggs, cut up ham and a pancake. Resident #1 did not eat any of the pancakes but did eat both the eggs and ham. (Facility staff) noticed resident was coughing and came over to assist. Resident did cough up some eggs and ham but was still distressed. Coordinators were notified and 911 was called. Family and physician were notified of the event and resident was sent to (the hospital) for further treatment. At approximately 9:30 am, this writer began the investigation to speak with all staff involved and gather statements. This writer also went to meet with Dietary Staff J about making sure proper diets were being sent out from the kitchen. Immediate education and in-service was given to the cooks regarding altered diets and textures.	S3026		

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	N046071	A. BUILDING: _____ B. WING _____	08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3026	Continued From page 7	S3026		

Coordinators were present for the next meal, lunch, to make sure altered diets were served correctly. All (certified staff) working on Monday, August 3, 2015 on the special care unit were in-serviced regarding altered diets and mechanical soft diets. Other (certified staff) were in-serviced when they arrived for their next shift. All (certified staff) working during the time of the incident were verbally coached regarding not serving the proper diet to resident #1. All resident diet orders and NSA/HSP were reviewed to make sure they were consistent and up to date.

Observations of lunch on 8-6-15 at 11:55 am on the special care unit revealed 6 residents around the table in the kitchen and the remainder of the residents in the dining room. Staff stated these residents required closer monitoring and assistance with eating. Menu included: Spinach Salad, Navy Bean Soup, Chicken Fricassee (baked chicken), Rice Pilaf, Seasoned Peas, Cottage Cheese, Reuben Sandwich, and Banana Split. The ground chicken for residents on mechanical soft diets was in a small separate container and plated for residents #2, #3, #4 and #5.

The administrator failed to ensure resident #1 was not subjected to neglect when facility staff failed to provide mechanically altered meat as ordered for this resident who had a history of pocketing food, choking, and aspiration pneumonia. This failure placed Resident #1 in immediate jeopardy for harm, injury or death. Resident #1 choked, aspirated and passed away at the hospital a few hours later. The jeopardy was removed on 8-3-15 when the resident passed away and Administrative staff A and Dietary Staff J in-serviced all dietary, certified and

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	N046071	A. BUILDING: _____ B. WING _____	08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3026	Continued From page 8 licensed staff regarding dietary policies and procedures to address other residents receiving a mechanical soft diet.	S3026		
S3155 SS=D	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 88 residents. The sample included 7 residents. Based on observation, record review and interview for 1(#1) of 7 sampled residents receiving a mechanically altered diet, the administrator failed to ensure that a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident when the facility nurse failed to address the cognitively impaired resident ' s tendency to pocket food and difficulty swallowing. Findings included: - Record review for resident #1 revealed admission to the special care unit of the facility on 4-3-15 with diagnoses Dementia, Hypertension, Hyperlipidemia, History of Stroke, Coronary Artery Disease, Peripheral Neuropathy, Degenerative	S3155		

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	N046071	A. BUILDING: _____ B. WING _____	08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3155	Continued From page 9 Joint Disease, Peripheral Vascular Insufficiency, Depression, Anxiety and Constipation. The functional capacity screen (FCS) dated 4-7-15 recorded resident unable to perform bathing, dressing, toileting, transfers, and management of medications/treatments; physical assistance with walking/mobility and supervision of eating. Incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks identified: impaired vision, impaired hearing, and impaired decision-making. The negotiated service agreement/health care service plan (NSA/HCSP) recorded the following services: Diet Restrictions: 4-24-15 Mechanical Soft; 4-25-15 Please Chopped up foods. Dining and Nutrition: Level of Assistance: Step by step cueing. Resident is cueing assist with diet. Team members will offer cues to eat when resident is not eating on own. 4-25-15 Chopped up food Mechanical Soft diet. 3 meals per day, prefers full portions. The NSA/HCSP lacked services to address resident ' s use/need for adaptive utensils, difficulty with swallowing, tendency to pocket food and tendency to shovel food into mouth until full. The NSA/HCSP documented administrative nurse C was responsible for the implementation and supervision of the plan. Physician ' s orders: 4-21-15: " Change diet to Mechanical Soft. " 5-28-15: " Hospice evaluation and treatment. " Hospice Skilled Nursing Notes:	S3155		

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 _____	08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF LENEXA	15055 WEST 87TH ST PARKWAY LENEXA, KS 66215

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S3155	Continued From page 10	S3155		

6-1-15: " Patient just ate lunch, ate 25% of the meal and family states he/she ate all his/her breakfast. Patient needs to be monitored through meals for feeding assistance and is a high risk for aspiration, oral care to be provided after each meal and check patient occasionally while he/she is eating to monitor for pocketing food ... "
6-4-15: " ...Lungs are clear, does have a history of aspiration pneumonia, and is on a mechanical soft diet and needs to be monitored for pocketing food, needs assist with meals and drinks ...coordinated care with (licensed staff B) and (family members)

Progress Notes:
8-3-15 at 12:03 pm: [note incident occurred at approximately 8:15 a.m.] " This writer was called to the 3rd floor. A team member called and stated (resident #1) was choking. . . . Resident was sitting in his/her wheelchair at the Kitchen table. His/her color was pale and resident was gasping for air. I said to call 911 and was told (staff member) was calling 911. I ask if the Heimlich was done and was told yes with no results.. . . . " Resident #1 was transported to the hospital. Signed by licensed staff D.
8-3-15 at 12:07 pm: " Call to hospital for update on resident who was admitted with Acute Aspiration and Respiratory Distress. Resident was being moved from the emergency room to intensive care unit. Family was with him/her. " Signed by licensed staff D.
8-3-15 at 8:56 pm: (Administrative staff B) received a message from resident ' s family around 3:30 pm that resident had passed. " Signed by administrative staff B.

Interview on 8-5-15 at 11:55 am with administrative staff A stated when resident ate, he/she " shoveled " food into his/her mouth

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S3155	Continued From page 11 continuously until mouth was full. Interview on 8-5-15 at 12:50 pm with certified staff F stated resident used big handled spoons and forks to eat with and fed self. For two weeks prior to incident, noticed resident was pocketing food in his/her mouth and staff would have to cue him/her to swallow, and offer fluids. Stated resident usually ate in the kitchen for closer monitoring and if he/she was disruptive and combative, they had him/her eat in the activity room but still within view of staff. Stated they just knew to do this. Confirmed he/she was not sitting with resident and providing cueing on 8-3-15. Interviews on 8-5-15 and 8-6-15 with certified staff G stated he/she gave resident medications; stated resident " had trouble swallowing even with medications crushed and placed in applesauce. " Further confirmed he/she would have to wait until the resident swallowed the medications; resident #1 would sometimes pocket his/her medications, not swallow and the medication along with the applesauce would have to be removed from the resident ' s mouth with the spoon if he/she was not chewing. Interview on 8-5-15 at 1:15 pm with certified staff H stated he/she was told by the family that " he/she will eat and eat and eat and look like a chipmunk (full cheeks) and they ' ll slowly go down (his/her cheeks). " he/she had thick rubber utensils, he/she shovels the food in, really goes at it. " Stated staff cannot take resident ' s plate to help slow him/her down when eating because the resident gets upset and yells (" Food! Food! "), want the plate " NOW " , very demanding. " Interview on 8-5-15 at 1:59 pm with administrative	S3155		

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 _____	08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 12	S3155		

nurse C stated he/she didn ' t know resident was pocketing food, but knew the resident had a problem swallowing. Confirmed the resident utilized adapted utensils and this was not documented on the HCSP. Further confirmed the NSA/HCSP lacked documentation of instructions to staff to address resident ' s pocketing of food and swallowing problems.

Interview on 8-10-15 at 11:10 am with certified staff I confirmed resident #1 had difficulty with eating and pocketing food, stated resident, " always had a problem ...had to tell him/her to spit stuff out. " Confirmed he/she was not given any instructions, written or verbal, from any of the nurses regarding management of resident ' s eating behavior and diet.

Written statement provided on 8-6-15 at 11:15 am by administrative staff A stated:
" On Monday, August 3, 2015 at approximately 8:50 am, this writer was notified by administrative nurse C that we were sending resident #1, a confused resident at (the facility) to the hospital due to difficulty in breathing. Upon investigation it was determined that resident #1 was choking on his/her breakfast. He/she was served scrambled eggs, cut up ham and a pancake ... (Facility staff) noticed resident was coughing and came over to assist. Resident did cough up some eggs and ham but was still distressed ...911 was called ...and resident was sent to (the hospital) for further treatment. ..All (certified staff) working on Monday, August 3, 2015 on the special care unit were in-serviced regarding altered diets and mechanical soft diets. Other (certified staff) were in-serviced when they arrived for their next shift. All (certified staff) working during the time of the incident were verbally coached regarding not serving the proper diet to resident #1. All resident

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 _____	08/10/2015

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
S3155	Continued From page 13	S3155		

diet orders and NSA/HSP were reviewed to make sure they were consistent and up to date. "
The facility lacked documentation that certified staff were in-serviced regarding assisting residents who shovel large amounts of food into mouth with difficulty swallowing and pocketing of food.

Review of documentation provided by the facility regarding staff in-service on 8-3-15 and 8-4-15 revealed all staff instructed on Modified Therapeutic Diets policies and procedures; Food Safety and Therapeutic Diets Training and testing (for dietary staff only). The in-service lacked documentation of health care interventions to address residents with difficulty swallowing and tendency to pocket food.

Interviews on 8-6-15 at 12:00 pm with certified staff F, G and K stated resident #1 was the only current resident who pocketed food, but residents #2 and 3 had difficulty swallowing at times.

Observations of lunch on 8-6-15 at 11:55 am on the special care unit revealed 6 residents around the table in the kitchen and the remainder of the residents in the dining room. Staff stated these residents required closer monitoring and assistance with eating. Menu included: Spinach Salad, Navy Bean Soup, Chicken Fricassee (baked chicken), Rice Pilaf, Seasoned Peas, Cottage Cheese, Reuben Sandwich, and Banana Split. The ground chicken for residents on mechanical soft diets was in a small separate container and plated for residents #2, #3, #4 and #5.

For resident #1, the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that

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S3155	Continued From page 14 met the needs of the cognitively impaired resident who had a tendency to pocket food and had difficulty swallowing. The resident was given ham that was not ground up, was not monitored by staff during eating, choked, aspirated and passed away at the hospital a few hours later.	S3155		