STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087087	A. BUILDING: _____ B. WING _____	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES MEMORY HAVEN	1500 S 183RD ST W GODDARD, KS 67052

(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 represents the findings of an Abbreviated Survey for complaints 179844 and 179917 for the above named Assisted Living facility conducted on 05/09/23 and 05/10/23.	S 000		
S3240 SS=F	26-41-103 (c) Staff Development on Dementia (c) If the facility admits residents with dementia, the administrator or operator shall ensure the provision of staff orientation and in-service education on the treatment and appropriate response to persons who exhibit behaviors associated with dementia. This REQUIREMENT is not met as evidenced by: KAR 26-41-103 (c) The Memory Care facility reported a census of 14 residents and identified all 14 residents with cognitive impairment. Based on interview and record review for two of four newly hired direct care staff, the executive director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to persons who may exhibit behaviors associated with dementia. On 05/10/23 at 08:15 AM Administrative Nurse B provided dementia training for Certified Medication Aide (CMA) F and stated CMA E had checked out the dementia training but had not completed the test yet. She also reported CMA E only worked one night shift for the facility. Administrative Nurse B was not able to provide evidence of dementia training for CMA C who	S3240		

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
	N087087	A. BUILDING: _____ B. WING _____	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVE ESTATES MEMORY HAVEN	1500 S 183RD ST W GODDARD, KS 67052

(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
S3240	Continued From page 1 had a hire date of 02/15/23 or CMA D who had a hire dated 04/26/23. The executive director failed to ensure the provision of staff orientation and in-service education on the treatment and appropriate responses to residents regarding dementia training.	S3240		