

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF OVERLAND PARK OPERATIONS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 NIEMAN ROAD OVERLAND PARK, KS 66210		
(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 a resurvey with complaints (#181184, #179481, #174286, #174100, #173800, #172528, #172539, #170795, #170509, #170361) at the above named facility conducted on 07/11/23 and 07/12/23.	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.	S3028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f) (3) The facility reported a census of 48 residents. The sample included 3 residents. Based on record review and interviews for 1 Resident (R)3, Operator/ Licensed Nurse (LN) A failed to ensure each incident of potential abuse was thoroughly investigated when bruising was noted on R3's inner thigh(s) and she presented to the emergency room with pelvic pain. Findings included: - Review of R3's medical record revealed she admitted to the facility on 03/28/20 with diagnoses of Parkinson's, insomnia, cognitive communication deficit, major depressive disorder, hyperlipidemia and hypertension. R3's "Functional Capacity Screen (FCS)/ Negotiated Service Agreement (NSA)" dated 04/26/23 recorded the resident as independent with eating, required supervision with bathing, dressing, toileting, transfer and walk/mobility and required physical assistance to perform management of medications and treatments. R3 was usually continent of urine, was understandable/ usually understood and was at risk for falls/ unsteadiness. The FCS/NSA lacked signatures of the individuals involved at the time of development of	S3028		

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S3028	Continued From page 2 the agreement including R3 and any legal representatives or family members. R3's current "Service Plan" dated 04/06/23 recorded facility staff provided medication administration, supervision with bathing, assisted with dressing and changing ileostomy, and supervised transfers. used a wheelchair for mobility and required supervision from staff with transfers. The "Service Plan" further recorded R3 as independent with transferring to toilet and used a wheelchair for mobility. Reports indicated R3 was potentially abused by staff in June 2022. Discharge report from hospital dated 06/14/22 recorded reason for visit as traumatic pelvic pain and pain with ambulation. Record lacked a fully completed, thorough investigation of accusation by facility reported to the department. Interview on 07/12/23 at 12:18 PM with Administrative Staff D stated alleged perpetrator (staff) was suspended pending investigation and further confirmed unable to locate the fully completed investigation of accusation of abuse reported to the department. Facility's "Abuse, Neglect and Exploitation" policy (no date) recorded, "Investigation Procedure: 4. The Director or his/her designee is to start an investigation as soon as he/she is made aware of the allegation. This investigations is the be completed and provided to the appropriate regulatory agency within five working	S3028		

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S3028	Continued From page 3 days or seven calendar days (if the timeframe includes weekend days) ... 5. The Director must take immediate action to protect the resident involved in the occurrence and all other residents ...6. The Director or his/her designee must interview the resident involved and a statement written as to what the resident said. 7. The Director or his/her designee must interview the staff member that is the alleged perpetrator or may have knowledge of the event and document the details of the interview. 8. The Director or his/her designee is to have the alleged perpetrator write a statement as to what events occurred. This statement is to be written on the state required form and must be notarized. 9. The Director or his/her designee is to interview all other staff members that were on duty at the time of the alleged occurrence and document the details of the interview(s). 10. All staff members that were on duty at the time of the alleged occurrence are to write a statement as to what events occurred. This statement is to be written on the state required form and must be notarized. 11. The Director or his/her designee is to interview at least three other alert and oriented residents on the same hall/unit as the resident whom the complaint is regarding. The details of the interview are to be documented." Operator/LN A failed to ensure each incident of potential abuse was thoroughly investigated when bruising was noted on R3's inner thigh(s) and she presented to the emergency room with pelvic pain.	S3028		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration	S3202		

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S3202	Continued From page 4 (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) (4) The facility reported a census of 48 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 5 non-sampled Residents (R)6, R7, R8, R9 and R10 requiring insulin by injection, Operator/ Licensed Nurse (LN) A failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens for the residents without an assessment for competency by a licensed nurse. Findings included: - The "Resident Roster" obtained on 07/11/23 from Licensed Nurse (LN) B identified five residents as receiving insulin by injection (R6, R7, R8, R9 and R10). Review of sampled personnel records on 07/11/23 recorded the following Certified Medication Aide (CMA) recently hired, competency exams for dialing insulin pens were requested.	S3202		

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S3202	Continued From page 5 CMA H, hire date 02/15/23 CMA I, hire date 09/12/22 Interview on 07/12/23 at 12:50 PM with Operator/ LN A confirmed competency check offs for CMA's to dial insulin pens, including CMA H and CMA I, were not completed. Interview on 07/11/23 at 12:46 PM with CMA H stated she dialed insulin pens for residents to self-inject. Facility provided a "Competency Checklist: Flexpen and Flextouch Insulin Pens with Autocover Safety Needle" but failed to provide a policy for dialing of insulin pens by a CMA. Operator/LN A failed to ensure the licensed nurse delegated nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto when medication aides dialed insulin pens for the residents without an assessment for competency by a licensed nurse.	S3202		
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	S3240		

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S3240	Continued From page 6 by: KAR 26-41-103 (c) The facility reported a census of 48 residents. The sample included 3 residents and review of 5 newly hired employees. Based on interview and personnel record review, Operator/ Licensed Nurse (LN) A failed to ensure the provision of employee orientation and in-service education upon hire for 3 (Certified Medication Aide (CMA) H, CMA I and Certified Nurse Aide (CNA) J) of 5 sampled employees on the treatment and appropriate response to persons who exhibit behaviors associated with dementia and Alzheimer's and with the potential to affect all residents. Findings Included: - On 07/11/23, LN B provided a "Resident Roster" which revealed a total census of 48 residents with 16 housed on the locked memory care unit and 32 housed on the assisted living unit. Twenty-seven residents listed on the roster were identified as having impaired cognition. Review of CMA H's employee record revealed they hired onto the facility on 02/15/23 and the record lacked documentation of dementia and Alzheimer's training upon hire. Review of CMA I's employee record revealed they hired onto the facility on 09/12/22 and the record lacked documentation of dementia and Alzheimer's training. Review of CNA J's employee record revealed they hired onto the facility on 11/21/22 and the	S3240		

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S3240	Continued From page 7 record lacked documentation of dementia and Alzheimer's training upon hire. Interview on 07/11/23 at 03:19 PM with Operator/LN A confirmed CMA H, CMA I and CNA J's record lacked documentation of dementia and Alzheimer's training on hire. Interview on 07/12/23 at 12:47 PM with Administrative Staff D confirmed Dementia and Alzheimer's training was to be completed upon hire and annually with all staff. Electronic interview on 07/12/23 at 03:29 PM with LN C confirmed facility did not have a policy on Dementia training. Operator/LN A failed to ensure the provision of employee orientation and in-service education for 3 of 5 sampled employees on the treatment and appropriate response to persons who exhibit behaviors associated with dementia and Alzheimer's and with the potential to affect all residents.	S3240		
S3261 SS=D	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:	S3261		

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S3261	Continued From page 8 KAR 26-41-105 (f) (11) The census totaled 48 residents. The sample included 3 residents. Based on record review and interview for 1 Resident(R)2, Operator/ Licensed Nurse (LN) A 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 when a male resident was found in R2's bed. Findings included: - R2's "Medical Record" revealed he admitted to the facility on 10/10/19 with diagnoses of Alzheimer's Disease, dementia, major depressive disorder, hypertension, hyperlipidemia and heart failure. R2 resided on the locked memory care unit of the facility. The "Functional Capacity Screen (FCS)/ Negotiated Service Agreement (NSA)/dated 04/05/23 recorded the resident required supervision with eating and physical assistance required for bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. The "FCS/NSA" recorded R2 was frequently incontinent of urine, had short- and long-term memory impairment, impaired memory/ recall, impaired decision making, was usually understandable/ sometimes understood communication, was at risk for falls/ unsteadiness and had impaired vision. The "Service Plan" dated 01/23/23 recorded facility staff assisted with bathing, dressing, toileting and management of medications. The "Service Plan" recorded R2 as independent with	S3261		

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S3261	Continued From page 9 transfers and wore a walking boot and used a walker for ambulation. Nurse's Note dated 06/25/23, entered 06/29/23 by LN B recorded, "Upon arrival to facility, went to check in on [R2]. No injuries or change in behavior were observed." Nurse's Note date 06/26/23, entered 06/29/23 by LN B recorded, "On 06/25 I was notified that [family member of R2] had called the facility to notify staff that she had observed a man in her mom's room sitting on her bed via the camera. CNA [Certified Nurse Aide] that answered the phone ran to the memory care side, grabbed the other CNA and CMA [Certified Medication Aide] and ran to [R2's] room to intervene. When they entered, they observed a male resident sitting on the edge of the bed, with the covers partially drawn back, rubbing [R2's] stomach. Staff immediately helped male resident up and escorted him to the dining room while one CNA stayed back to check on [R2]. [R2] remained asleep during the encounter and no injuries were visualized by staff." Record lacked a Nurse's Note completed on 06/25/23 when incident occurred. Record lacked documentation of resident condition/ assessment at time of incident and follow up assessment. Interview on 07/12/23 at 12:42 PM with LN B confirmed she did not assess on site or document on 06/25/23 when incident occurred and further confirmed no Nurse's Note was completed until 06/29/23. LN B stated she	S3261			

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S3261	Continued From page 10 completed a video call with R2 on 06/25/23 but confirmed no documentation of video assessment. Facility's "Accidents and Occurrences" policy (no date) recorded, "d. The RCC or designee will proceed as follows: i. Review all documentation (Occurrence report, 24-hour report, CNA assignment sheet, NSA, nurse's notes documentation) for completeness; ii. Complete a thorough investigation of the occurrence to determine casual factors; iii. Review occurrence and findings with Director ... vi. Check the nurse's notes for three days to ensure follow-up documentation is completed." Operator/LN A 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 when a male resident was found in R2's bed.	S3261		
S3265 SS=J	26-41-104 (a) Disaster and Emergency Preparedness (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (a)	S3265		

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S3265	Continued From page 11 The facility reported a census of 48 residents. The sample included 3 residents and 2 focused review residents. Based on interview and record review for 1 focused review Resident (R)4, who required two person assist to transfer, Operator/Licensed Nurse (LN) A failed to ensure the provision of a sufficient number of staff members on night shift to take all residents who would require assistance in an emergency or disaster to a secure location. This failure placed residents in this facility in immediate jeopardy for harm, injury, or death. Findings included: - On 07/11/23 at 12:15 PM during the initial tour with Operator/LN A revealed a locked memory care unit within the facility. The "Resident Roster" obtained on 07/10/23 from Licensed Nurse (LN) B recorded a total census of 48 residents with 16 housed on the locked memory care unit and 32 housed on the assisted living unit. Twenty-seven residents listed on the roster were identified as having impaired cognition. One resident listed on the roster (R4) was identified as requiring two staff for transfer assistance. R4 resided in the assisted living unit.. On 07/11/23 at 01:32 PM, Operator/LN A confirmed due to short staffing, two staff members were scheduled in the facility at times on night shift, instead of three staff members, from 11:00 PM to 07:00 AM and further confirmed staff on duty was a CMA (Certified Medication Aide) and CNA (Certified Nurse Aide). This staffing pattern left no staff members on the	S3265		

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S3265	Continued From page 12 memory care unit if R4, who resided on the assisted living unit, required the care of two staff members during the night shift. On 07/11/23 at 01:54 PM, Operator/ LN A confirmed R4 required two-person assistance for transfers from bed to wheelchair. Staffing of only 2 staff members at night would require the memory care staff to leave the locked unit unattended to assist with transfers of R4. - Record review for R4 revealed she admitted on 08/16/22 with diagnoses of vascular dementia, reduced mobility, need for assistance with personal care, muscle weakness, emphysema, chronic obstructive pulmonary disease, and cognitive communication deficit. R4's "Functional Capacity Screen (FCS)/ Negotiated Service Agreement (NSA)" dated 02/10/23 recorded the resident required physical assistance with eating and was unable to perform bathing, dressing, toileting, transfer, walk/mobility and management of medications and treatments. The FCS/NSA recorded R4 was frequently incontinent, had short-term memory impairment, difficulty with memory/recall, impaired decision making and was usually understandable/ usually understood. socially inappropriate/ disruptive behavior. R4 was at risk for falls/ unsteadiness and had impaired vision. The resident's "Service Plan" dated 08/13/22 recorded R4 used a bed cane and wheelchair for mobility and required physical staff assistance in an evacuation. Interview on 07/11/23 at 02:41 PM with Certified	S3265		

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S3265	Continued From page 13 Nurse Aide (CNA) E stated R4 required two-person assistance for transfers. Interview on 07/11/23 at 02:45 PM with Certified Medication Aide (CMA)/CNA F stated R4 required two-person assistance for transfers and further stated they used a draw sheet to transfer R4 from bed to wheelchair. Interview on 07/11/23 at 01:32 PM with Operator/LN A confirmed they were unable to locate a completed annual evacuation with all residents of the facility and two staff members to a secure location. Operator/LN A further confirmed they were unable to locate quarterly reviews of the emergency management plan completed with residents for the second, third and fourth quarter of 2022 and the first and second quarter of 2023. Operator/LN A further confirmed unable to locate quarterly reviews of the emergency management plan completed with staff for the second and fourth quarter of 2022 and the second quarter of 2023. On 07/11/23 at 03:43 PM, LN C provided the staffing schedule for June 2023 and July 2023. Operator/LN A confirmed only two staff members on duty from 11:00 PM to 07:00 AM every night in June 2023 except one night (06/08/23) and further confirmed only two staff members were on duty from 11:00 PM to 07:00 AM from 07/01/23 to 07/10/23, except one night (07/09/23). On 07/13/23 at 03:48 PM, surveyor informed Operator/LN A, LN C and Administrative Staff D of immediate jeopardy for failure to ensure sufficient staff in the facility at all times for safe evacuation of residents requiring assistance of	S3265		

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF OVERLAND PARK OPERATIONS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 NIEMAN ROAD OVERLAND PARK, KS 66210		
(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
S3265	Continued From page 14 two staff. Operator/LN A failed to ensure the provision of sufficient staff to take all residents to safety in the event of an emergency/evacuation on the night shift. The current roster included 48 residents, which included one resident who required two staff to assist with transfers. The current July 2023 staff schedule included two staff members on duty overnight from 11:00 PM to 07:00 AM daily except for one night (07/09/23)., with a minimum of two staff members on duty from 11:00 PM to 07:00 AM since 08/16/22, when R4 admitted to the facility. This failure placed residents in this facility in immediate jeopardy for harm, injury or death. Jeopardy was removed on 07/11/23 at 04:53 PM when the following signed abatement plan was received from Operator/LN A: This abatement was identified for insufficient staffing on the night shift at Homestead of Overland Park. The Operator stated the abatement was to state that there would be three staff members 24 hours a day as long as there was a resident who required two people to transfer them and staff the locked Memory Care. There would be one staff member in Memory Care at all times and 2 staff members on Assisted Living." The abatement plan included a staffing schedule from 07/11/23 through 07/13/23 to include three staff members on duty overnight from 11:00 PM to 07:00 AM. Operator/ Licensed Nurse (LN) A failed to ensure	S3265		

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S3265	Continued From page 15 the provision of a sufficient number of staff members on night shift to take all residents who would require assistance in an emergency or disaster to a secure location. This failure placed residents in this facility in immediate jeopardy for harm, injury, or death.	S3265		
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 secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104 (d) (3) (4) The census equaled 48 residents. The sample included 3 residents and review of 5 employee records. Based on record review and interview, Operator/ Licensed Nurse (LN) A failed to ensure	S3280		

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S3280	Continued From page 16 disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with residents and staff and an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. Facility failed to provide quarterly reviews of the emergency management plan with residents for the second, third and fourth quarters of 2022 and the first and second quarters of 2023. Review of the facility's quarterly reviews of the emergency management plan with staff revealed the following review dates: 09/22 and 01/31/23. The facility failed to provide documentation regarding emergency management plan reviews with staff for the second and fourth quarters of 2022 and the second quarter of 2023. Facility failed to perform an annual emergency drill since last survey conducted with all residents and the minimum number of staff on duty at one time that included an evacuation of all residents to a secure location. Interview on 07/11/23 at 01:32 PM with Operator/	S3280		

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S3280	Continued From page 17 LN A confirmed unable to locate reviews completed with residents and further confirmed unable to locate reviews completed with staff for the second and fourth quarters of 2022 and the second quarter of 2023. Operator/ LN A also confirmed no annual emergency drill completed with all residents to a secure location with minimum number of staff on duty at one time. On 07/12/23, facility's disaster and emergency preparedness policy requested, and LN C provided the state's disaster and emergency preparedness regulations. Operator/LN A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with residents and staff and an annual emergency drill with staff and residents to include an evacuation of the residents to a secure location.	S3280		
S3299 SS=E	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e) The census equaled 48 residents. The sample	S3299		

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S3299	Continued From page 18 included 3 residents. Based on record review, interview, and observation for all residents receiving meal services, Operator/ Licensed Nurse (LN) A failed to ensure the facility staff stored all food under safe and sanitary conditions. Findings included: - Observation during the initial tour on 07/11/23 at 12:25 PM revealed a kitchen containing food/drinks. Observation on 07/11/23 at 12:08 PM revealed memory care unit residents eating lunch in the dining room of the unit. Observation of the refrigerator revealed the following food items, which were not dated: one bottle of Thousand Island dressing (32 ounces each), two bottles of French dressing (32 ounces each), two containers of Taco Sauce (8.44 pounds each), one Ziploc bag containing sliced cheese and one unidentifiable squeeze bottle containing liquid. The refrigerator had one pan containing fruit, which was not completely sealed. Interview on 07/11/23 with Dietary Staff G confirmed the above listed food items were without open dates. Facility's "Food Storage" policy dated 04/06/20 recorded, "1. General storage guidelines to be followed: Label all food items. The label must include the name of the food and the date it was opened or prepared, OR the date it should be sold, consumed or discarded ...Store leftover	S3299		

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S3299	Continued From page 19 contents of cans and prepared food in clean, sanitized containers with proper and secure covers." For all residents of the facility, Operator/ LN A failed to ensure the facility staff stored all food under safe and sanitary conditions.	S3299		