

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10101 W 127TH ST OVERLAND PARK, KS 66213		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #191593, #191090, #189823, #188861, #188862, #187317, #185557, #184441, #184443, #184045, #183671, #183464, and #182522 at the above named assisted living conducted on 02/10/25 - 02/13/25.	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: K.A.R. 26-41-101 (f)(3) The facility reported a census of 52 "Residents" (R)'s. Based on interview and record review the Operator failed to report to the department an allegation of neglect involving R14 within 24 hours as soon as she was made aware of the allegation. Findings included: - Review of the complaint to the department dated 10/26/23 revealed an allegation that the licensed nurse allowed a non-certified medication aide to administer insulin to R14. Record Review for R14 revealed an admission date of 03/13/23 with diagnoses of depression, hypertension, type 2 diabetes, syncope and collapse and atherosclerotic heart disease of native coronary artery without angina. Review of R14's "Functional Capacity Screen" (FCS) dated 03/13/24 revealed R14 lacked the ability to manage his own medications. Review of R14's "Negotiated Service Agreement" (NSA) dated 03/13/24 identified the facility would manage the administration of R14's medications.	S3028		

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S3028	Continued From page 2 Review of R14's "Health Service Plan" (HSP) instructed facility staff to provide extensive assistance with R14's medications. Review of the undated facility policy titled "Medication Administration" revealed the following; 2. The administration of oral, ophthalmic, optic, inhalant, nasal, rectal, vaginal, topical, and injectable subcutaneous medications may be delegated by the Wellness Director/Licensed Nurse Designee to a Certified Medication Aide. Review of facility provided handwritten notes dated 10/30/23 from a conversation between Operator C and CMA A revealed the following; Operator C wrote that she asked CMA if she gave insulin to a resident on 10/21/23. Operator C wrote "This is against the "regs" (regulations) and not part of your license, why? Operator C wrote that CMA A responded "I was directed by the nurse to do it" Operator C then wrote that she told CMA A it was not in her scope of practice. You cannot do anything that involves needles. Operator C then wrote that she asked CMA C "why would you go against your certification?" Operator C wrote that CMA A responded that she had given insulin before and was trained. The note continued her Director of Nursing directed her to administer the insulin and CMA A understood her mistake, and she continued that she was following the direction of her supervisor.	S3028		

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S3028	Continued From page 3 Review of the facility provided document titled "Employee Counseling Form" dated 11/20/23 revealed Licensed Nurse (LN) B had on 10/21/24 directed a CMA to give insulin to a resident and gave the same CMA permission to pass medications on her shift. Record review of CMA A 's employee file revealed she began employment on 12/17/21. Review of the document titled "Nurse Aide Registry Conformation Notice" dated 12/17/21 revealed CMA A's certification expired on 08/24/23. Interview on 02/12/24 at approximately 01:55 PM with Operator C and CMA A confirmed they new the CMA's certification had expired at the time and Operator C confirmed she had taken CMA A off of the medication cart. CMA A confirmed that at her other place of employment the nurse trained the CMA's to hold the pen and the resident had to "push" the button. CMA A and Operator C confirmed the incident happened on a Saturday and CMA A reported it to Operator C on the following Monday. Interview on 02/12/24 at approximately 01:40 PM with LN B confirmed she did ask CMA A to pass medications and administer insulin to R14, she further confirmed she that new that CMA A's certification was expired. The Operator failed to report to the department an allegation of neglect involving R14 within 24 hours as soon as she was made aware of the allegation.	S3028		

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S3166	Continued From page 4	S3166		
S3166 SS=D	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (e) The facility reported a census of 52 "Residents" (R)'s. Based on interview and record review the Operator failed to ensure the "Licensed Nurse" delegated duties not included in the "Certified Medication Aide" Curriculum, respectively, under the Kansas Nurse Practice Act K.S.A. 65-1124 and amendments there to for the administration of insulin. Findings included: - Review of the complaint to the department dated 10/26/23 revealed an allegation that the licensed nurse allowed a non-certified medication aide to administer insulin to R14. Record Review for R14 revealed an admission date of 03/13/23 with diagnoses of depression, hypertension, type 2 diabetes, syncope and collapse and atherosclerotic heart disease of native coronary artery without angina.	S3166		

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S3166	Continued From page 5 Review of R14's "Functional Capacity Screen" (FCS) dated 03/13/24 revealed R14 lacked the ability to manage his own medications. Review of R14's "Negotiated Service Agreement" (NSA) dated 03/13/24 identified the facility would manage the administration of R14's medications. Review of R14's "Health Service Plan" (HSP) instructed facility staff to provide extensive assistance with R14's medications. Review of the undated facility policy titled "Medication Administration" revealed the following; 2. The administration of oral, ophthalmic, optic, inhalant, nasal, rectal, vaginal, topical, and injectable subcutaneous medications may be delegated by the Wellness Director/Licensed Nurse Designee to a Certified Medication Aide. Review of facility provided handwritten notes dated 10/30/23 from a conversation between Operator C and CMA A revealed the following; Operator C wrote that she asked CMA if she gave insulin to a resident on 10/21/23. Operator C wrote "This is against the "regs" (regulations) and not part of your license, why? Operator C wrote that CMA A responded "I was directed by the nurse to do it" Operator C then wrote that she told CMA A it was not in her scope of practice. You cannot do anything that involves needles. Operator C then wrote that she asked CMA C "why would you go	S3166		

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S3166	Continued From page 6 against your certification?" Operator C wrote that CMA A responded that she had given insulin before and was trained. The note continued her Director of Nursing directed her to do administer the insulin and CMA A understood her mistake, and she continued that she was following the direction of her supervision. Review of the facility provided document titled "Employee Counseling Form" dated 11/20/23 revealed Licensed Nurse (LN) B had on 10/21/24 directed a CMA to give insulin to a resident and gave the same CMA permission to pass medications on her shift. Record review of CMA A 's employee file revealed she began employment on 12/17/21. Review of the document titled "Nurse Aide Registry Conformation Notice" dated 12/17/21 revealed CMA A's certification expired on 08/24/23. Interview on 02/12/24 at approximately 01:55 PM with Operator C and CMA A confirmed they new the CMA's certification had expired at the time and Operator C confirmed she had taken CMA A off of the medication cart. CMA A confirmed that at her other place of employment the nurse trained the CMA's to hold the pen and the resident had to "push" the button. CMA A and Operator C confirmed the incident happened on a Saturday and CMA A reported it to Operator C on the following Monday. Interview on 02/12/24 at approximately 01:40 PM with LN B confirmed she did ask CMA A to pass	S3166		

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S3166	Continued From page 7 medications and administer insulin to R14, she further confirmed she that knew that CMAA's certification was expired. The Operator failed to ensure the "Licensed Nurse" delegated duties not included in the "Certified Medication Aide" Curriculum, respectively, under the Kansas Nurse Practice Act K.S.A. 65-1124 and amendments there to for the administration of insulin.	S3166		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d)	S3298		

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S3298	Continued From page 8 The facility reported a census of 52 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food and three satellite kitchens where staff stored and served food. Based on interview and record review, the operator failed to ensure dietary staff served food at the proper temperature to avoid bacterial growth in House 2. Findings included: - Review of the facility's "Weekly Meal Temps" Log from 02/01/25 to 02/10/25 revealed the log was blank on the following dates: 02/02/25 - breakfast, lunch, and dinner 02/03/25 - breakfast and lunch 02/05/25 - breakfast, lunch, and dinner 02/07/25 - breakfast, lunch, and dinner 02/08/25 - breakfast, lunch, and dinner 02/09/25 - breakfast, lunch, and dinner 02/10/25 - breakfast The log lacked food temperatures for 18 out of 27 meals. On 02/10/24 at approximately 12:48 PM Operator C confirmed the food temperature log for House 2 lacked evidence of documentation of food temperatures for all three meals daily. The facility's undated "Food Temperature Requirements" policy documented dining services staff would monitor food temperatures to ensure foods were served in compliance with established temperature guidelines and regulatory requirements.	S3298		

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S3298	Continued From page 9 The Kansas Department of Agriculture's "Focus on Food Safety" booklet documented "minimum hot holding temperature is 135 degrees Fahrenheit (F)." and "maximum cold holding temperature is 41 degrees F. The operator failed to ensure dietary staff served food at the proper temperature to avoid bacterial growth.	S3298		
S3299 SS=F	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 facility reported a census of 52 residents. The facility had a main kitchen where dietary staff stored, prepared, and served food and three satellite kitchens where staff stored and served food. Based on observation and interview the operator failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 02/10/25 at 12:34 PM of House 1 revealed a satellite kitchen with a refrigerator and freezer containing food items for the	S3299		

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S3299	Continued From page 10 residents. Facility staff failed to document refrigerator and freezer temperatures to ensure safe storage of food items. Observation on 02/10/25 at 12:48 PM of House 2 revealed a satellite kitchen with a refrigerator and freezer containing food items for the residents. Facility staff failed to document refrigerator and freezer temperatures to ensure safe storage of food items. Observation on 02/10/25 at 01:02 PM of House 3 revealed a satellite kitchen with a refrigerator and freezer containing food items for the residents. Facility staff failed to document refrigerator and freezer temperatures to ensure safe storage of food items. On 02/10/25 at approximately 12:48 PM Operator C confirmed Houses 1, 2, and 3 satellite kitchens did not have a refrigerator temperature log. The undated facility's "Refrigerator Temperatures" policy documented staff would check and log all refrigerator and freezer temperatures twice daily. The operator failed to ensure designated staff stored food items under safe conditions.	S3299		