STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046074	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF OVERLAND PARK	12500 W 135TH STREET OVERLAND PARK, KS 66221

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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 191450, 189249, 185413, 184371, 183134 at the above named assisted living facility conducted on 03/04/25 and 03/05/25.	S 000		
S3050 SS=E	26-41-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the facility. The administrator or operator shall ensure that this information is posted in an area readily accessible to all residents and the public. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(k) The facility reported a census of 63 residents. Based on observation and interview the administrator failed to ensure the ombudsman and the department's names, addresses, and telephone numbers were posted in a common area accessible to all residents and the public. Findings included: - Observation on 03/04/25 at 12:04 PM during	S3050		

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

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S3050	Continued From page 1 the initial tour revealed the ombudsman and the department's names, addresses, and telephone numbers were located in a frame sitting on the floor leaning against the activity director's desk on the second floor. On 03/05/25 at approximately 02:45 PM R5 stated she has no reason to go to the second floor and has not seen a posting of the ombudsman or department's information. On 03/05/25 at approximately 04:05 PM Administrative Staff A confirmed the ombudsman and the department's names, addresses, and telephone numbers were not posted inside memory care. The administrator failed to ensure the ombudsman and the department's names, addresses, and telephone numbers were posted in a common area accessible to all residents and the public.	S3050		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h)	S3101		

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S3101	Continued From page 2 The facility reported a census of 63 residents with six residents included in the sample and two closed record reviews. Based on record review and interview the administrator failed to ensure that each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreement for Resident (R) 1, R2, R3, R4, R5, and R6. Findings included: - Record review for R1 revealed an admission date of 03/11/23. The most recent Functional Capacity Screen (FCS) was dated 12/16/24. The most recent Negotiated Service Agreement (NSA) was dated 12/16/24 and lacked a signature page including all individuals involved in the development of the agreement. - Record review for R2 revealed an admission date of 09/27/23. The most recent Functional Capacity Screen (FCS) was dated 10/28/24. The most recent Negotiated Service Agreement (NSA) was dated 10/28/24 and lacked a signature page including all individuals involved in the development of the agreement. - Record review for R3 revealed an admission date of 07/06/21. The most recent Functional Capacity Screen	S3101		

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S3101	Continued From page 3	S3101		

(FCS) was dated 02/27/25.

The most recent Negotiated Service Agreement (NSA) was dated 02/27/25 and lacked a signature page including all individuals involved in the development of the agreement.

- Record review for R4 revealed an admission date of 11/14/23.

The most recent Functional Capacity Screen (FCS) was dated 01/03/25.

The most recent Negotiated Service Agreement (NSA) was dated 01/03/25 and lacked a signature page including all individuals involved in the development of the agreement.

- Record review for R5 revealed an admission date of 08/07/24.

The most recent Functional Capacity Screen (FCS) was dated 01/27/25.

The most recent Negotiated Service Agreement (NSA) was dated 01/27/25 and lacked a signature page including all individuals involved in the development of the agreement.

- Record review for R6 revealed an admission date of 09/20/24.

The most recent Functional Capacity Screen (FCS) was dated 02/27/25.

The most recent Negotiated Service Agreement (NSA) was dated 02/27/25 and lacked a signature page including all individuals involved

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S3101	Continued From page 4 in the development of the agreement. Interview on 03/05/25 at 02:15 PM of Administrative Staff C and Administrative Staff D confirmed R1, R2, R3, R4, R5, and R6's most recent NSA's lacked signatures by each individual involved in the development of the agreement. The administrator failed to ensure that each individual involved in the development of the NSA signed the agreements for R1, R2, R3, R4, R5, and R6.	S3101		
S3171 SS=F	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 63 residents. The sample included six residents and two closed chart reviews. The administrator failed to ensure the qualified staff provided healthcare services in accordance with acceptable standards of practice when staff failed to respond to call lights in a timely manner. Findings included: - Review of the facility provided resident roster	S3171		

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S3171	Continued From page 5	S3171		

revealed 46 residents required physical assistance with their activities of daily living.

Review of the call light report for 02/26/25 thru 03/03/25 revealed the following call light response times:

37 calls took greater than 30 minutes to answer.
14 calls took greater than 60 minutes to answer.
One call was responded to over 120 minutes later.
On 02/27/25 report alone, 7 calls were between 24 and 33 minutes.
Approximately 12.5% of the time, calls were answered over 30 minutes after a request for help was made.

On 03/05/25 at approximately 03:50 PM R3 stated many times staff respond 30-45 minutes after she presses her button and needs help. She stated that is too long for her needs.

On 03/05/25 at approximately 02:43 PM R5 stated she has waited for an hour and a half for a response to her call light and many mornings she does not get assistance to get ready and out of bed when she desires, and requests help by pulling call cord.

Interview on 03/05/25 at approximately 04:15 PM with Administrator A confirmed the expectation of staff answering the resident call lights is 15 minutes or less.

The administrator failed to ensure facility staff responded to call lights in a timely manner. This failure put all residents who required assistance for any reason at risk for delay in assistance, for

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S3171	Continued From page 6 falls, and potential illness or injury.	S3171		
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) The facility reported a census of 63 residents. Based on interview and record review the administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with all residents and staff. The administrator further failed to ensure disaster and emergency preparedness by ensuring the performance of an emergency drill annually with staff and residents	S3280		

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S3280	Continued From page 7 to include an evacuation of the residents to a secure location. Findings included: - Review of the facility's emergency plan records lacked evidence of documentation quarterly reviews were completed with staff during the second, third, and fourth quarter of 2024 and with all residents since the last survey. On 03/04/25 at 03:44 PM Administrative Staff A confirmed the facility's record lacked documentation reviews of the emergency management plan were completed quarterly with all residents and staff. - During entrance interview on 03/04/25 at 10:13 AM documentation of annual full evacuations were requested which the facility failed to provide. On 03/05/25 at approximately 02:45 PM R5 stated she had not reviewed emergency procedures except where to exit during a fire since her admission on 08/07/24. On 03/05/25 at approximately 03:45 PM R1 stated he had not reviewed emergency procedures except where to meet after exiting building during a fire since his admission on 03/11/23. Interview on 03/04/25 at 03:02 PM with Administrative Staff A confirmed the records lacked documentation for a full evacuation completed since last survey.	S3280		

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S3280	Continued From page 8 The facility's "Emergency Preparedness Plan" page 12 documented disaster training was performed at least once per year and testing drills at least twice per year for all staff. The administrator failed to provide evidence of documentation quarterly reviews of the facility's emergency management plan were completed with staff and further failed to ensure disaster and emergency preparedness by the failure to ensure the performance of an emergency drill annually with staff and residents to include an evacuation of the residents to a secure location.	S3280		
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 63 residents. The facility had a main kitchen where food was stored and prepared for all residents and a satellite kitchen where food was served to only memory care residents. Based on observation and interview the administrator failed to ensure food items were stored under safe conditions. Findings included:	S3299		

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S3299	Continued From page 9 - Observation on 03/04/25 at approximately 10:44 AM in the kitchen revealed a preparation table refrigerator that contained food items for the residents that contained the following food items. One container white shredded cheese, unsealed, unlabeled, undated One container pickle spears, undated One 32 ounce carton of scrambled egg mix, undated One 32 fluid ounce container of heavy whipping cream dated "2/1" and label that read use within seven days of opening On 03/04/25 at approximately 10:46 AM Dietary Staff F confirmed the food items were outdated, lacked labels identifying what was inside, and/or a date the food was opened or prepared. - Observation on 03/04/25 at 12:04 PM in the activity room revealed a refrigerator and cabinets that contained the following food items for the residents. The refrigerator contained: One can crescent rolls dated best by 4-10-24 One container 946 milliliter heavy whipping cream with no date opened, best by date 12/30/24 One container of reddish pink salad with no label identifying item or date it was prepared One plastic bag of hard and dried out tortillas unsealed and undated One bag of mild cheddar fine cut cheese, eight ounces with mold and best by date of 11/24/24	S3299		

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S3299	Continued From page 10 The cabinets contained: One 12 ounce bag Jet puffed marshmallows which were hard and dry, unsealed and undated One box graham crackers with best by date of 2/26/24 Two containers of brown sugar unlabeled identifying item or date opened One 96 fluid ounce container vegetable oil with best by date of 10/12/24 On 03/04/25 at approximately 12:10 PM Staff H confirmed the food items were not monitored well and were unlabeled, undated, and/or expired. The facility's "Food Storage, Preparation and Service" policy last updated 07/08/24 explained food items are labeled, dated and rotated as well as expired food items were discarded. The Kansas Department of Agriculture's "Focus on Food Safety" booklet Page 21 explains that commercially prepared foods must be date marked after the original container was opened and held under refrigeration. Foods prepared on site must be labeled and date marked for consumption or discarded within 24 hours. The administrator failed to ensure foods were stored under safe conditions.	S3299		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.	S3320		

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S3320	Continued From page 11 (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) The facility reported a census of 63 residents. Based on observation and interview the administrator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 03/04/25 at 11:11 AM of the care manager's office revealed the entry door was propped open with a door stop. Chemicals on the counter included one spray bottle of one quart Oxivir germicidal, one eight ounce aerosol	S3320		

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S3320	Continued From page 12 can of glade air freshener, and one container Microkill bleach wipes, 150 wipes, with labels that read "Keep out of reach of children." On 03/04/25 at approximately 11:20 AM Certified Medication Aide G confirmed the door was not locked and chemicals were not stored in locked areas. - Observation on 03/04/25 at approximately 12:11 PM of the activity room revealed an unlockable cabinet under the sink which included one 32 ounce spray bottle of clean shower and one 19 ounce aerosol can of glass cleaner with labels that read "Keep out of reach of children." On 03/04/25 at approximately 12:15 PM Maintenance Staff E confirmed the cabinet door did not have a lock and chemicals were not stored in locked areas. The facility's "Chemical Safety" policy dated 11/11/05 page one documented all designated secured storage locations are locked at all times and chemicals are not accessible to residents. Page 4 instructed departments to lock all chemicals in cabinets in the department/area. The administrator failed to ensure the building was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		
S3395 SS=F	28-39-255 LAUNDRY (c) Laundry facility. (1) The facility shall store soiled laundry in a	S3395		

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S3395	Continued From page 13	S3395		

manner which prevents odors and spread of disease.

(2) If laundry is processed in the facility, the facility shall provide washing and drying machines. The facility shall arrange the work area to provide a "one-way flow" of laundry from a soiled area to a clean area.

(3) The facility shall provide a work counter and a locked cabinet for storage of chemicals and supplies.

(4) The facility shall provide a handwashing lavatory with a non-reusable method of hand-drying within or accessible to the laundry facility.

This REQUIREMENT is not met as evidenced by:
KAR 28-39-255(c)(2)(3)

The facility reported a census of 63 residents. Based on observation and interview the administrator failed to ensure the laundry work area had a "one-way flow" from a soiled area to a clean area and a work counter.

Findings included:

- Observation on 03/04/25 at 11:10 AM of the first-floor laundry room revealed it lacked a work countertop.

On 03/04/25 at 11:10 AM Maintenance Staff E confirmed the room did not have a work counter. A nearby Certified Nurse Aide stated the laundry

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S3395	Continued From page 14 was taken to the "care manager's office" to fold. - Observation on 03/04/25 at 12:22 PM of the memory care laundry room revealed two washers split apart on the outsides of two dryers and it lacked a work countertop. On 03/04/25 at 12:22 PM Maintenance Staff E confirmed the room did not have a work counter and the setup did not provide for one-way flow from a soiled area to a clean area. The administrator failed to ensure the laundry work areas had a "one-way flow" from a soiled area to a clean area and a work counter.	S3395		