

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S 000                                                               | INITIAL COMMENTS<br><br>The following citations represent the findings of a<br>resurvey with complaint numbers 194075 and<br>194217 at the above named Assisted Living<br>Facility conducted on 05/27/25, 05/28/25,<br>05/29/25 and 06/02/25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | S 000                                                                                           |                                                                                                                          |                                                        |
| S3085<br>SS=E                                                       | 26-41-202 (a) Negotiated Service Agreement<br><br>(a) The administrator or operator of each<br>assisted living facility or residential health care<br>facility shall ensure the development of a written<br>negotiated service agreement for each resident,<br>based on the resident ' s functional capacity<br>screening, service needs, and preferences, in<br>collaboration with the resident or the resident ' s<br>legal representative, the case manager, and, if<br>agreed to by the resident or the resident ' s legal<br>representative, the resident ' s family. The<br>negotiated service agreement shall provide the<br>following information:<br>(1) A description of the services the resident will<br>receive;<br>(2) identification of the provider of each service;<br>and<br>(3) identification of each party responsible for<br>payment if outside resources provide a service.<br><br>This REQUIREMENT is not met as evidenced<br>by:<br>KAR 26-41-202(a)(1)<br><br>The facility reported a census of 66 residents<br>with six residents included in the sample and one<br>focused review. Based on interview and record<br>review the administrator failed to ensure the | S3085                                                                                           |                                                                                                                          |                                                        |

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

TITLE

(X6) DATE

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3085                                                               | <p>Continued From page 1</p> <p>"Negotiated Service Agreements" (NSA) for Resident (R) 1, R2, R3, R4, and R6 described the services they received for cognition based on their "Functional Capacity Screen" (FCS).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Record review for R1 revealed an admission date of 02/03/24 with a diagnosis of early onset Alzheimer's Disease.</li> </ul> <p>The 02/03/25 "FCS" identified R1 had short-term and long-term memory, memory/recall, and decision making cognitive difficulties.</p> <p>The 02/03/25 "NSA" failed to describe the services R1 received for cognition.</p> <ul style="list-style-type: none"> <li>- Record review for R2 revealed an admission date of 10/31/24 with diagnoses of dementia and cognitive communication deficit.</li> </ul> <p>The 03/10/25 "FCS" identified R2 had short-term memory, memory/recall, and decision making cognitive difficulties.</p> <p>The 03/10/25 "NSA" failed to describe the services R2 received for cognition.</p> <ul style="list-style-type: none"> <li>- Record review for R3 revealed an admission date of 02/05/22 with a diagnosis of traumatic brain injury.</li> </ul> <p>The 05/28/25 "FCS" identified R3 had short-term memory, memory/recall, and decision making cognitive difficulties.</p> | S3085                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3085                                                               | Continued From page 2<br><br>The 05/28/25 "NSA" failed to describe the services R3 received for cognition.<br><br>- Record review for R4 revealed an admission date of 06/26/20 with a diagnosis of Alzheimer's Disease.<br><br>The 05/07/24 "FCS" identified R4 had short-term memory, memory/recall, and decision making cognitive difficulties.<br><br>The 05/07/24 "NSA" failed to describe the services R4 received for cognition.<br><br>- Record review for R6 revealed an admission date of 11/15/18 with a diagnosis of dementia.<br><br>The 10/31/24 "FCS" identified R6 had short-term and long-term memory, memory/recall, and decision making cognitive difficulties.<br><br>The 10/31/24 "NSA" failed to describe the services R6 received for cognition.<br><br>The administrator failed to ensure the "NSAs" for R1, R2, R3, R4, and R6 described the services they received for cognition. | S3085                                                                                           |                                                                                                                          |                                                        |
| S3200<br>SS=D                                                       | 26-41-205 (d) (1-2) Facility Administration of Medications<br><br>(d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | S3200                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3200                                                               | <p>Continued From page 3</p> <p>of practice, and each manufacturer ' s<br/>recommendations. The administrator or operator<br/>shall ensure that all of the following are met:<br/>(1) Only licensed nurses and medication aides<br/>shall administer and manage medications for<br/>which the facility has responsibility.<br/>(2) Medication aides shall not administer<br/>medication through the parenteral route.</p> <p>This REQUIREMENT is not met as evidenced<br/>by:<br/>KAR 26-41-205(d)</p> <p>The facility reported a census of 66 residents<br/>with six residents included in the sample and one<br/>focused review. Based on interview and record<br/>review the administrator failed to ensure facility<br/>staff administered four medications to Resident<br/>(R) 6 in accordance with her medical care<br/>provider's orders.</p> <p>Findings included:</p> <p>- Record review for R 6 revealed an admission<br/>date of 11/15/18 with diagnoses of dementia and<br/>anxiety.</p> <p>The 10/31/24 "Functional Capacity Screen"<br/>(FCS) identified R6 required physical assistance<br/>with management of medications.</p> <p>The 10/31/24 "Negotiated Service Agreement"<br/>(NSA) identified facility nurse or Certified</p> | S3200                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3200                                                               | <p>Continued From page 4</p> <p>Medication Aide (CMA) administered medications as prescribed by physician.</p> <p>The 08/06/23 "Physician's Order" documented escitalopram 10 milligram (mg) tablet, give one tablet by mouth every day for depression.</p> <p>The 08/06/23 "Physician's Order" documented quetiapine 25 mg tablet, give 0.5 tablet (12.5 mg) by mouth three times a day for dementia with psychosis.</p> <p>The 12/12/23 "Physician's Order" documented clonidine 0.1 mg tablet, give one tablet by mouth every day at noon for hypertension.</p> <p>The 04/01/25 "Physician's Order" documented lorazepam 0.5 mg tablet, give one tablet three times a day for anxiety.</p> <p>Review of R6's "Medication Administration Record" (MAR) from 04/01/25 to 05/27/25 revealed lack of evidence of documentation facility staff administered the following medications to R6 on the following dates:</p> <p>Escitalopram (once daily): 04/04, 04/05, 04/06, 04/08, 04/12, 04/17, 04/25, 04/27, 04/30, 5/11, and 5/23 for a total of nine out of 30 missed opportunities during the month of April and two out 27 missed opportunities during the month of May.</p> <p>Quetiapine (three times daily): once on 04/03, twice on 04/04, twice on 04/05, twice on 04/06, once on 04/08, once on 04/12, once on 04/17, once on 04/25, once on 04/30, once on 05/11, and once on 05/23 for a total of 10 out of 90</p> | S3200                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3200                                                               | Continued From page 5<br><br>missed opportunities during the month of April<br>and two out of 81 missed opportunities during<br>the month of May.<br><br>Clonidine (once daily): 04/04, 04/05, 04/06,<br>04/08, 04/12, 04/17, 04/25, 04/27, 04/30, 05/02,<br>05/11, and 05/23 for a total of nine out of 30<br>missed opportunities during the month of April<br>and three out 27 missed opportunities during the<br>month of May.<br><br>Lorazepam (three times daily): twice on 04/05,<br>twice on 04/06, once on 04/08, once on 04/12,<br>once on 04/17, once on 04/25, once on 04/27,<br>once on 04/30, once on 5/11, and once on 5/23<br>for a total of 10 out of 90 missed opportunities<br>during the month of April and two out of 81<br>missed opportunities during the month of May.<br><br>On 05/28/25 at approximately 03:52 PM<br>Administrative Nurse C stated if there was a<br>blank on a resident's MAR the medication was<br>not given.<br><br>The administrator failed to ensure facility staff<br>administered four medications to R6 in<br>accordance with her medical care provider's<br>orders. | S3200                                                                                           |                                                                                                                          |                                                        |
| S3299<br>SS=F                                                       | 26-41-206 (e) (1) Facility Food Storage<br><br>(e) Food storage. Facility staff shall store all<br>food under safe and sanitary conditions.<br>(1) Containers of poisonous compounds and<br>cleaning supplies shall not be stored in the areas<br>used for food storage, preparation, or serving.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | S3299                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3299                                                               | <p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:<br/>KAR 26-41-206(e)</p> <p>The facility reported a census of 66 residents. The facility had a galley kitchen where dietary staff stored and served food for all residents. Based on observation and interview the administer failed to ensure designated staff stored food items under safe conditions.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Observation on 05/27/25 at approximately 12:50 PM of the galley kitchen revealed a refrigerator which contained the following items:</li> </ul> <p>One opened 46-ounce carton of prune juice, undated.<br/>One opened 64-ounce carton of almond milk, undated.<br/>One opened 64-ounce plastic jug of apple juice, undated.<br/>One opened 60-ounce cranberry juice cocktail, undated.<br/>One opened gallon of orange juice, undated.</p> <p>The galley kitchen counter had an unlabeled plastic pitcher of an unknown, yellow-colored liquid at room temperature.<br/>-Observation on 05/27/25 at 12:55 PM revealed no temperature log present for the galley kitchen refrigerator.</p> <p>On 05/27/25 PM at approximately 12:57 PM</p> | S3299                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3299                                                               | Continued From page 7<br><br>Administrative Staff F verified foods in refrigerator and counter were unlabeled and/or unsealed or past their date of use.<br><br>On 05/27/25 PM at approximately 1:07 PM Administrative Staff G confirmed there was no temperature log present for the galley kitchen refrigerator.<br><br>The facility's undated "Open and Closing Kitchen Checklist" instructed staff to check temperatures and complete temperature log for all coolers and to ensure all food items were labeled covered properly for storage.<br><br>The administrator failed to ensure designated staff stored food items under safe conditions.                                                                                                                                                                                        | S3299                                                                                           |                                                                                                                          |                                                        |
| S3305<br>SS=F                                                       | 26-41-207 (a) (b) Infection Control<br><br>(a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents.<br>(b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements:<br>(1) Using universal precautions to prevent the spread of blood-borne pathogens;<br>(2) techniques to ensure that hand hygiene meets professional health care standards;<br>(3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards;<br>(4) providing sanitary conditions for food service; | S3305                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3305                                                               | <p>Continued From page 8</p> <p>(5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident 's food, or resident care equipment until the condition is no longer infectious;</p> <p>(6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and</p> <p>(7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>KAR 26-41-207(b)(2)(4)</p> <p>The facility reported a census of 66 residents. The facility had a main kitchen where dietary staff cleaned/sanitized dishware for all residents in a high-temperature dishwasher. Based on observation and interview the administrator failed to ensure designated staff implemented hand hygiene procedures to prevent the spread of infection and failed to ensure dietary staff kept water temperature records for the dishwasher.</p> <p>Findings included:</p> <p>- The 01/17/25 "Infection Control - Handwashing" signature sheet revealed 21 staff</p> | S3305                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3305                                                               | <p>Continued From page 9</p> <p>signed they received hand hygiene training.</p> <p>Observation on 05/27/25 at 01:26 PM revealed Certified Nurse Aide (CNA) E exited a resident apartment, opened a large trash bin in the common area, and threw in a bag and gloves. She entered another resident apartment. No hand sanitizer appeared available in the common area or near resident rooms.</p> <p>Observation on 05/27/25 at 01:27 PM revealed Resident (R) 7 laid in bed sleeping with two clean incontinence briefs laying near the end of his bed next to where CNA E stood. A sink in the apartment appeared dry and unused. A paper towel dispenser above the sink was empty. No hand sanitizer was in or near R 7's apartment.</p> <p>On 05/27/25 at approximately 01:27 PM CNA E stated she had changed a resident's brief and threw it in the trash. Then she entered R7's apartment and picked up some items because R7 "took apart everything." She had not performed hand hygiene yet because had not begun to touch or take care of R7 yet.</p> <p>On 05/27/25 at 04:36 PM Administrative Nurse C stated staff were to wash their hands with water and soap between each resident when providing cares. Hand sanitizer was available at the front desk and on each of three medication carts.</p> <p>On 05/28/25 at 09:33 AM Administrative Staff A stated he expected staff to wash hands before entering a resident's apartment not after they had already touched items in the resident's room.</p> <p>The facility's undated "Hand Hygiene Policy and</p> | S3305                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3305                                                               | <p>Continued From page 10</p> <p>Procedures" documented all staff must adhere to hygiene practices that meet professional healthcare standards including handwashing and using hand sanitizers. Staff performed hand hygiene after handling soiled waste, after removing gloves, and upon entering and exiting a resident's room. Hand sanitizing stations should be strategically place throughout the facility, including entrances, hallways, and near resident rooms.</p> <p>The administrator failed to ensure designated staff implemented hand hygiene procedures to prevent the spread of infection.</p> <p>- Observation of the kitchen on 05/27/25 at approximately 12:55 PM revealed a high-temperature dishwasher but no available water temperature log.</p> <p>On 05/27/25 at approximately 12:59 PM Dietary Staff G confirmed there was no water temperature log available for the dishwasher.</p> <p>On 05/29/25 at approximately 10:34 AM a dishwasher policy was provided upon request. The policy documented "dishwasher temps need to be completed each shift."</p> <p>The Kansas Department of Agriculture's "Focus on Food Safety" booklet documented "hot water sanitation range is 180 degrees Fahrenheit (F) at the manifold and 160 degrees Fahrenheit at plate level."</p> <p>The administrator failed to ensure dietary staff kept water temperature logs for the high-temperature dishwasher.</p> | S3305                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3310<br>SS=F                                                       | <p>26-41-207 (b) (5-6) (c) Infection Control Policies</p> <p>(b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious;</p> <p>(6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and</p> <p>(c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105</p> <p>This REQUIREMENT is not met as evidenced by:<br/>KAR 26-41-207(c)</p> <p>The facility reported a census of 66 residents. Based on interview and record review the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two of five sampled staff.</p> <p>Findings included:</p> <p>- Review of Licensed Nurse J's employee record revealed a hire date of 09/19/23. Her record lacked evidence of documentation she completed a two-step TB skin test and a TB</p> | S3310                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3310                                                               | <p>Continued From page 12</p> <p>symptom screen questionnaire within seven days of hire.</p> <p>Review of Certified Medication Aide (CMA) K's employee record revealed a hire date of 07/22/24. Her record lacked evidence of documentation of the second step of a two-step TB skin test and a symptom screen questionnaire within seven days of hire.</p> <p>On 05/29/25 at approximately 04:15 PM Administrative Staff A confirmed License Nurse J's and CMA K's employee records lacked evidence of documentation they completed the two-step TB skin test and completed TB symptom screen questionnaires within seven days of hire.</p> <p>The undated facility's "Infection Control - Tuberculosis" policy documented "each new employee shall have an intital tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) test completed within seven days of employment.</p> <p>The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee shall receive a two-step TB skin test and symptom screen questionnaire within seven days of employment.</p> <p>The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.</p> | S3310                                                                                           |                                                                                                                          |                                                        |
| S3320<br>SS=E                                                       | <p>28-39-254 CONSTRUCTION</p> <p>(a) The assisted living facility or residential</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | S3320                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3320                                                               | <p>Continued From page 13</p> <p>health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.</p> <p>(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.</p> <p>(c) New construction, modifications and equipment shall conform to the following codes and standards:</p> <p>(1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and</p> <p>(2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>KAR 28-39-254(a)</p> <p>The facility reported a census of 66 total residents. The facility had a kitchen in the memory care unit where dietary staff stored and served food for all 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.</p> | S3320                                                                                           |                                                                                                                          |                                                        |

Kansas Department on Aging

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                          |                                                        |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>N046065</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL OAKS AT LEAWOOD</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5201 W 143RD STREET<br/>OVERLAND PARK, KS 66224</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S3320                                                               | <p>Continued From page 14</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Observation on 05/27/25 at approximately 01:18 PM revealed an unlocked door under the sink with the following chemicals:</li> </ul> <p>One-gallon plastic container of Triple S DC PINE disinfectant cleaner.<br/>One spray bottle with unidentified green liquid<br/>One container SSDC coffee pot cleaner</p> <p>On 05/27/25 Administrative Nurse D verified the unlocked chemicals under memory care kitchen sink.</p> <p>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.</p> | S3320                                                                                           |                                                                                                                          |                                                        |