

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER SILVERCREST AT DEER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 13060 METCALF AVENUE OVERLAND PARK, KS 66213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints #195254 and #190591 at the above named assisted living conducted on 08/12/25.	S 000		
S 135 SS=D	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(B)	S 135		

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

TITLE

(X6) DATE

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S 135	Continued From page 1 The facility reported a census of 32 residents with three residents included in the sample and one focused review. Based on interview and record review the administrator failed to ensure licensed staff consulted with Resident (R) 2's physician and notified her legal representative or designated family member when she developed a red area on her left leg and when the red area developed into an open sore. Findings included: - Record review for R2 revealed an admission date of 10/17/24 with diagnoses of dementia, history of falling, and heart failure. The 02/13/25 "Functional Capacity Screen" (FCS) identified R2 was unable to perform management of treatments. The 02/13/25 "Negotiated Service Agreement" (NSA) failed to describe services R2 received for wound treatments. The 07/28/25 nursing "Progress Note" documented R2's left leg was swollen and red and hot to the touch. The nurse received a new order for an antibiotic. The note lacked evidence of documentation licensed staff consulted R2's physician and notified her legal representative or designated family member. The 07/31/25 nursing "Progress Note" documented R2 had a 3.0 centimeters (cm) long by 3.0 cm wide red area on her leg that home health monitored. The note lacked evidence of documentation licensed staff consulted R2's	S 135		

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S 135	Continued From page 2 physician and notified her legal representative or designated family member. The 08/05/25 nursing "Progress Note" documented the nurse practitioner examined R2 and ordered another antibiotic and a wound culture test for R2's wound. The note lacked evidence of documentation licensed staff notified R2's legal representative or designated family member. On 08/12/25 at 04:13 PM Administrative Nurse B confirmed the record lacked documentation of R2's wound when staff reported to her the red area had developed into an open sore. On 08/12/25 at 05:05 PM a nursing documentation policy was requested which the facility failed to provide. The administrator failed to ensure licensed staff consulted the physician and notified the legal representative or designated family members when R2 developed a red area on her left leg and when the red area developed into an open sore.	S 135		
S3171 SS=D	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by:	S3171		

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S3171	Continued From page 3 KAR 26-41-204(i) The facility reported a census of 32 residents with three residents included in the sample and one focused review. Based on interview and record review the administrator failed to ensure designated staff provided staple removal timely to Resident (R) 4. Findings included: - Record review for R4 revealed an admission date of 04/22/22 with a diagnosis of dementia. The 12/05/24 "Functional Capacity Screen" (FCS) identified R4 was unable to perform management of treatments. The 10/01/24 "Negotiated Service Agreement" (NSA) identified R4 required storage and application for treatments. The 08/26/24 hospital "After Visit Summary" included instructions which read "return to the emergency department for staple removal in one week." The 08/27/24 nursing "Progress Note" documented R4 returned from the hospital on 08/26/25 with staples in the back of her head requiring removal in one week. The 09/09/24 at 01:16 PM nursing "Progress Note" documented R4 received staple removal on 09/07/24 which was past the seven-day removal date.	S3171		

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S3171	Continued From page 4 On 08/12/25 at 04:27 PM Administrative Nurse B confirmed R4's staples were removed later than seven days. The administrator failed to ensure designated staff provided staple removal timely to Resident (R) 4.	S3171		
S3175 SS=E	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 32 residents with three included in the sample. Based on interview and record review the administrator	S3175		

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S3175	Continued From page 5 failed to ensure a licensed nurse performed assessments to determine if Resident (R) 1 and R3 could safely self-administer medications. Findings included: - Record review for R1 revealed an admission date of 08/01/25 with a diagnosis of diabetes mellitus The 07/29/25 "Functional Capacity Screen" (FCS) identified R1 was unable to perform management of medications. The 07/29/25 "Negotiated Service Agreement" (NSA) identified facility staff administered medications. R1's record lacked evidence of documentation a licensed nurse completed a medication self-administration assessment. On 08/12/25 at 03:48 PM Administrative Nurse B confirmed R1's record lacked evidence of documentation a licensed nurse completed a medication self-administration assessment. On 08/12/25 at 04:36 PM R1 stated facility staff brought him his insulin pen to his apartment and dialed the dose. He then administered the insulin himself. - Record review for R3 revealed an admission date of 10/17/24 with a diagnosis of chronic pain. The 06/06/25 "FCS" identified R3 was independent with management of medications.	S3175		

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S3175	Continued From page 6 The 06/06/25 "NSA" identified R3 self-administered her medications. The 06/09/25 "Self Administration of Medications Competency Evaluation" lacked a signature of a licensed nurse. On 08/12/25 at 04:11 PM Administrative Nurse B confirmed R3's record lacked evidence of documentation a licensed nursed completed a medication self-administration assessment. On 08/12/25 at 05:05 PM a self-administration policy was requested which the facility failed to provide. The administrator failed to ensure a licensed nurse performed assessments to determine if R1 and R3 could self-administer medications safely.	S3175		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced	S3186		

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S3186	Continued From page 7 by: KAR 26-41-205(b) The facility reported a census of 32 residents with three residents included in the sample and one focused review. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Resident (R) 1 identified who was responsible for the administration and management of select medications for insulin. Findings included: - Record review for R1 revealed an admission date of 08/01/25 with a diagnosis of diabetes mellitus The 07/29/25 "Functional Capacity Screen" (FCS) identified R1 was unable to perform management of medications. The 07/29/25 "NSA" identified facility staff administered medications and R1 required insulin. The "NSA" failed to identify who administered insulin. On 08/13/25 at 03:48 PM Administrative Nurse B stated R administered his own insulin and confirmed R1's "NSA" failed to identify who administered insulin. On 08/12/25 at 04:36 PM R1 stated facility staff brought him his insulin pen to his apartment and dialed the dose. He then administered the insulin himself.	S3186		

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S3186	Continued From page 8 On 08/12/25 at 05:05 PM a self-administration policy was requested which the facility failed to provide. The administrator failed to ensure R1's "NSA" identified who was responsible for the administration and management of select medications.	S3186		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 32 residents with three residents included in the sample and one focused review. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the date, time, action taken, and results of the action for Resident (R) 2 developed an open sore. Findings included: - Record review for R2 revealed an admission	S3261		

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S3261	Continued From page 9 date of 10/17/24 with diagnoses of dementia, history of falling, and heart failure. The 02/13/25 "Functional Capacity Screen" (FCS) identified R2 was unable to perform management of treatments. The 02/13/25 "Negotiated Service Agreement" (NSA) "NSA" failed to describe services R2 received for wound treatments. The 07/28/25 nursing "Progress Note" documented R2's left leg was swollen and red and hot to the touch. The nurse received a new order for an antibiotic. The note lacked evidence of documentation of the time, action taken, and results of the action. The 07/31/25 nursing "Progress Note" documented R2 had a 3.0 centimeters (cm) long by 3.0 cm wide red area on her leg that home health monitored. The note lacked evidence of documentation of the time, action taken, and results of the action. The 08/05/25 nursing "Progress Note" documented the nurse practitioner examined R2 and ordered another antibiotic and a wound culture test for R2's wound. Review of nursing notes from 07/31/25 when R2 had red area until 08/05/25 (five days) when R2 had an open wound that required more antibiotic treatment and wound culture lacked evidence of documentation of the wound after it developed, including time of origin, wound sizes (length, width, and depth), odor, tissue characteristics (including drainage, granulation), any signs of	S3261		

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S3261	Continued From page 10 infection, and a plan for treatment. On 08/12/25 at 04:13 PM Administrative Nurse B confirmed the record lacked documentation of R2's wound when staff reported to her the red area had developed into an open sore. On 08/12/25 at 05:05 PM a nursing documentation policy was requested which the facility failed to provide. The administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the date, time, action taken, and results of the action for R2 when a red area developed into an open sore.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location.	S3280		8/12/25

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S3280	Continued From page 11 This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 32 residents. Based on interview and record review the administrator failed to provide evidence of documentation designated staff provided reviews of the facility's complete emergency management plan with residents and staff every quarter. Findings included: - Review of the facility's emergency management plan from previous survey 01/30/24 to present revealed designated staff failed to conduct quarterly reviews of the complete emergency management plan. On 08/12/25 at approximately 12:21 PM Administrative Staff A and Administrative Nurse B confirmed facility records lacked evidence of documentation of quarterly reviews for the residents and employees. On 08/12/25 at 05:05 PM an emergency management plan policy was requested which the facility failed to provide. The administrator failed to provide evidence of documentation designated staff provided reviews of the facility's complete emergency management plan with residents and staff very quarter.	S3280		

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S3299	Continued From page 12	S3299		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 32 residents. The facility had a main kitchen and satellite kitchen. Based on observation and interview the administrator failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 08/12/25 at approximately 10:08 AM of the assisted living satellite kitchen revealed the following items in refrigerator contained the following food items for the residents that lacked date labels when they were opened or prepared: One opened jug of cranberry light 64-ounce (oz) drink One opened 48 oz container of prune juice One prepared pitcher of tea 08/11/25 no content identifier One opened cottage cheese 5-pound (lb) plastic container	S3299		

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S3299	Continued From page 13 One opened jug of salsa 4 lb 4 oz One square container of what appeared to be applesauce with prepared date 08/10/25 no content identifier One opened individual lemonade bottle 20 oz drink Observation on 08/12/25 at approximately 10:20 AM in the reach in refrigerator in main kitchen lacked date labels when they were opened or prepared: One opened plastic one-gallon container of mayonnaise One opened container of salsa 4lb 4 oz One prepared pitcher of red liquid unlabeled and undated One opened plastic container of cran light 64 oz drink One opened plastic apple juice carton 46 oz Observation on 08/12/25 at approximately 10:57 AM main kitchen's dry storage room lacked date labels when they were opened or prepared: One square container of rice labeled 08/08 One opened plastic one-gallon container Worcestershire sauce with no lid Two plastic one-gallon jugs of soy sauce One opened Over the Top cookie icing 10 oz tube with no cap or open date One opened plastic one-gallon jug of red wine vinegar One opened plastic one-gallon jug of vanilla extract One opened plastic one-gallon jug of real lime juice One opened clear plastic bag of partially used	S3299		

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S3299	Continued From page 14 pudding pie filling dry mix One plastic container of baking powder with loosely fitting lid with no open date One opened plastic package of flour tortillas Observation on 08/12/25 at approximately 11:08 AM of main kitchen's walk-in refrigerator revealed the following food items: One clear container of moldy strawberries One egg was broken in half in a stack of intact eggs Observation on 08/12/25 at approximately 11:11 AM main kitchen's reach in freezer lacked open date and product identification labels: One clear opened plastic bag of chicken strips One clear opened plastic bag of hamburger patties One clear opened plastic bag of mozzarella cheese One clear opened plastic bag of sweet potato fries One clear opened plastic bag of straight cut french fries On 08/12/25 Dietary staff D at approximately 11:20 AM Dietary Staff D confirmed designated staff failed to store food items under safe and sanitary conditions. The Kansas Department of Agriculture's 2025 "Focus on Food Safety" booklet documented food items must be date marked if they were time or temperature controlled for safety, ready-to-eat, prepared on-site, original container was opened, or held under refrigeration.	S3299		

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S3299	Continued From page 15	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (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. (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: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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; (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 (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	S3305		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER SILVERCREST AT DEER CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 13060 METCALF AVENUE OVERLAND PARK, KS 66213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3305	Continued From page 16 health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(b)(4) The facility reported a census of 32 residents. Based on observation and interview the administrator failed to ensure designated staff maintained sanitary conditions for food handling. Findings included: - Review of the facility's "Daily Cleaning List," "Weekly Cleaning List," "Bi Weekly Cleaning List," "Server Cleaning List," and "Cook Cleaning List," revealed they were all blank. Observation on 08/12/25 at approximately 10:44 AM of the facility's main kitchen revealed the following: 1) A food steamer sat on a counter with two sides and the back removed. The wires and mechanical components were exposed on the right side. A 2.0 inch (in) long by 1.0 in wide piece of fiberglass insulation was exposed on the left side of the steamer. To the left of the steamer within 8.0 to 10.0 in from the exposed fiberglass was an iced tea maker that was open on the top with iced tea inside. 2) The walk-in refrigerator ceiling vents had visible dust accumulation build up. 3) An exposed garbage disposal under a sink had visible dust and what appeared to be grease	S3305		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/12/2025
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S3305	Continued From page 17 accumulation build up. 4) A portable stainless steel air conditioner unit sat on top of a plastic milk crate had visible dust and what appeared to be grease accumulation build up. On 08/12/25 at approximately 10:44 AM Dietary Staff D confirmed the cleaning forms were blank. 08/12/25 at 05:05 PM a kitchen cleaning and maintenance policy was requested which the facility failed to provide. The administrator failed to ensure designated staff maintained sanitary conditions for food handling.	S3305		