

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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 represent the findings of a resurvey for the above named home plus conducted on 09/25/25.	S 000		
S5105 SS=E	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a)(1)(2) The facility reported a census of 11 residents with three included in the sample. Based on interview and record review Operator A failed to ensure the "Negotiated Service Agreements" (NSA) for Residents (R) 2, and R3 described the services they received based on their "Functional Capacity Screens" (FCS).	S5105		

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

TITLE

(X6) DATE

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5105	Continued From page 1 Findings included: - Record review for R2 revealed an admission date of 1/11/25 with a diagnosis of dementia. The 06/17/25 FCS identified R2 required supervision for transfers, walking and mobility. R2 required physical assistance with bathing, dressing, and toileting. R2 was occasionally incontinent of bladder and had impaired memory recall, was at risk for falls, and impaired vision. The 06/17/25 NSA identified R2 required physical assistance for bathing, dressing, and toileting. R2 required stand-by assistance for transfers, walking and mobility as needed. The NSA failed to identify R2 received services for memory recall, falls/unsteadiness, and impaired vision. On 09/25/25 at approximately 12:38 PM Operator A and Administrative Nurse B confirmed that R2 did not have services listed on NSA for memory recall, falls/unsteadiness, and impaired vision. Operator A failed to ensure the NSA for R2 described the services he received for memory recall, falls/unsteadiness, and impaired vision. - Record review for R3 revealed an admission date of 10/31/22 with a diagnosis of Alzheimer's. The 11/18/24 FCS identified R3 required physical assist with bathing, dressing, toileting, transferring, walking/mobility, and eating. R3 had impaired short term memory, long term	S5105		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5105	Continued From page 2 memory, memory recall, impaired decision making, communication difficulty, and was sometimes understandable The 11/18/24 NSA identified that R3 required physical assist with bathing, dressing, toileting, and eating. R3 required two staff assist for transfers with a mechanical lift. The NSA instructed staff "due to cognitive decline staff will look for gestures that I am in pain following the pain AD scale". The NSA failed to list services provided for communication. On 09/25/25 at approximately 12:38 PM Operator A and Administrative Nurse B confirmed that R2 did not have services listed on NSA for communication. Operator A failed to ensure the NSA for R2, and R3 described the services they received based on their FCS.	S5105		
S5310 SS=E	26-42-205 (e) (f) (g 1 - 3) Medication Orders, Ordering, Labeling (e) Medication orders. Only a licensed nurse or a licensed pharmacist may receive verbal orders for medication from a medical care provider. The licensed nurse shall ensure that all verbal orders are signed by the medical care provider within seven working days of receipt of the verbal order. (f) Standing orders. Only a licensed nurse shall make the decision for implementation of standing orders for specified medications and treatments formulated and signed by the resident 's medical care provider. Standing orders of medications	S5310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5310	Continued From page 3 shall not include orders for the administration of schedule II medications or psychopharmacological medications. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(e) The facility reported a census of 11 residents with three included in the sample. Based on observation and interview Operator A failed to ensure the Licensed nurse ensured all verbal orders were signed by the medical care provider within seven working days of receipt of the "Physician's Orders" for Resident (R) 2, and R3. Findings included: - Record review for R2 revealed an admission date of 01/11/25 with a diagnosis of dementia. The 06/17/25 "Functional Capacity Screen" (FCS) identified R2 required physical staff assist with bathing, dressing, toileting, stand by assistance with transfers, and one staff assistance with walking, and mobility as needed. R2 was unable to perform management of medications and treatments, was occasionally incontinent of bladder, had difficulty with memory recall, and was at risk for falls/unsteadiness and impaired vision. The 06/27/25 "Negotiated Service Agreement" (NSA) identified facility staff would provide R2 assistance twice a week with bathing, assistance	S5310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5310	Continued From page 4 of one with dressing, and toileting. R2 would require standby assistance with transferring and was occasionally incontinent with bladder. The NSA identified facility staff managed medications and treatments. Cognition, falls/unsteadiness and impaired vision were not addressed on the NSA. The 08/15/25 "Physician's Order" "Senna S one tablet BID(twice a day) for three days, decrease to daily, hold for loose stool" was not signed by the medical provider until 09/05/25 which was 21 days. The 09/09/25 "Physician Order" to "DC (discontinue) Ketorolac 0.5% ophthalmic solution, prednisolone 1%" not been signed by medical provider as of survey on 09/25/25 which was 16 days. Operator A failed to ensure the Licensed nurse ensured all verbal orders were signed by the medical care provider within seven working days of receipt of the "Physician Order." Record review for R3 revealed an admission date of 10/31/22 with a diagnosis of Alzheimer's. The 11/18/24 FCS identified R3 required physical assist with bathing, dressing, toileting, transferring, walking/mobility, and eating. R3 had impaired short term memory, long term memory, memory recall, and impaired decision making, and had communication difficulty and was sometimes understandable. The 11/18/24 NSA revealed that R3 required one staff assisting with bathing, dressing, toileting, and eating. R3 required two staff to assist with transfers with the mechanical lift. The NSA	S5310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5310	Continued From page 5 instructed staff "due to cognitive decline staff will look for gestures that I am in pain following the pain AD scale". The NSA failed to list services provided for communication. The "Physician Order" dated 10/29/24 documented "1) DC acetaminophen 650 (milligrams) (mg) BID, 2) tramadol 50 mg three times a day po (by mouth), 3) acetaminophen 325 mg tablet: 2 tablets (650mg) every eight hours as needed" was signed by medical provider on 11/21/24 which was 23 days. The "Physician Order" dated 12/20/24 documented "Zofran 4 mg one tablet every 6 hours as needed for nausea and vomiting" signed by medical provider on 12/28/25 which was eight days. The "Physician Order" dated 10/2/2024 documented "1) acetaminophen 325 mg tablets: two tablets (650 mg) po BID 2) DC quetiapine" signed by medical provider on 10/17/24 which was 15 days. The "Physician Order" dated 1/26/25 documented "DC left elbow treatment area healed" signed by the medical provider on 02/28/25 which was 33 days. The "Physician Order" dated 03/22/25 documented "1) change diet to puree with thin liquids 2) may crush medications per order due to swallowing issues" signed by medical provider on 04/19/25 which was 28 days. On 9/25/25 at 1:35 PM Operator A and Administrative Nurse B confirmed medical	S5310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5310	Continued From page 6 provider's "Physician Orders" for R2 and R3 were not signed within seven working days. Operator A failed to ensure the Licensed nurse ensured all verbal orders were signed by the medical care provider within seven working days of receipt of the "Physician's Orders" for R2, and R3.	S5310		
S5315 SS=D	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy	S5315		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5315	Continued From page 7 provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h)(4) The facility reported a census of 11 residents. Based on observation and interview, Operator A failed to ensure Licensed nurse and "Certified Medication Aide" (CMA) did not administer medication beyond the manufacturer or pharmacy providers recommended date of expiration, and that all medications and biologicals were securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations. Findings included: - Observation on 09/25/25 at 10:16 AM in an open accessible sitting room had a public hand washing area revealed a bottle of prescription nystatin powder for "Resident" (R)1 unattended by facility staff. On 09/25/25 at approximately 10:40 AM Operator A stated that Resident (R)1 received this several times a day and that CMA C was probably administering it and set it down to help	S5315		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5315	Continued From page 8 other residents. Observation on 09/25/25 at 10:49 AM revealed CMA C unlocked and opened the medication cart. Inside the medication cart was an opened clear plastic package that contained sodium chloride inhalation solution 0.9% vials with stamped expiration date of 04/16/24 which had expired 526 days before the start of the survey. On 09/25/25 at approximately 10:52 AM CMA C confirmed that the clear plastic package containing vials of sodium chloride inhalation solution 0.9% had a stamped expiration date of 04/16/24. On 09/25/25 at approximately 11:05 AM Administrative Nurse B confirmed that the clear plastic package containing vials of sodium chloride inhalation solution 0.9% had a stamped expiration date of 04/16/24. Operator A failed to ensure Licensed nurse and CMA did not administer medication beyond the manufacturer or pharmacy providers recommended date of expiration, and that all medications and biologicals were securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S5315		
S5335 SS=D	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.	S5335		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5335	Continued From page 9 (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. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a) The facility reported a census of 11 residents. Based on observation and interview Operator A failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area. Findings included: - Observation on 09/25/25 at approximately 10:10 AM revealed a hall closet in the entry way hallway. The closet had sliding doors and the lock to the right sliding door was unlocked with keyed lock hanging unsecured with a sign directly above the lock that informed facility staff "door must be locked at all times." The closet contained the following chemicals: Two spray bottles of carpet stain remover 32 ounces (oz) Four squirt bottles of toilet bowl cleaner 32 oz Two bottles of concentrated multi-purpose surface cleaner 80 oz Three spray bottles of window cleaner 7 oz Three bottles of DBK non-acid disinfectant cleanser one-quart bottles	S5335		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B089092	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN HEARTS HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11701 W 60TH PL SHAWNEE, KS 66203		
(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
S5335	Continued From page 10 Two spray bottles of power clinging gel cleanser 24 oz One spray bottle of air freshener 8.8 oz One aerosol bottle of multi-insect bottle 15 oz On 09/25/25 at approximately 10:49 AM Operator A confirmed the hall with chemicals was unsecured. Operator A failed to ensure the building was maintained to protect the health and safety of the residents by ensuring all chemicals were stored within a locked area.	S5335		