

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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 an initial survey for the above named home plus conducted on 12/17/25 and 12/18/25.	S 000		
S5029 SS=F	26-42-101 (g) Availability of policies and procedures (g) Availability of policies and procedures. Each administrator or operator shall ensure that policies and procedures related to resident services are available to staff at all times and are available to each resident, legal representatives of residents, case managers, and families during normal business hours. A notice of availability shall be posted in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(g) The facility reported a census of five residents. Based on observation and interview the operator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a public accessible area. Findings included: - Observation on 12/17/25 at approximately 11:02 AM during the initial tour revealed a notice that the facility's policies and procedures were available was not posted. On 12/17/25 at 12:29 PM during a phone interview Administrative Staff A confirmed a	S5029		

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: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5029	Continued From page 1 notice of the facility's policies and procedures available was not posted. The operator failed to ensure a notice of the availability of the facility's policies and procedures was posted in a place accessible to all residents.	S5029		
S5050 SS=F	26-42-101 (k) Ombudsman (k) Ombudsman. Each administrator or operator shall ensure the posting of the names, addresses, and telephone numbers of the Kansas department on aging and the office of the long-term care ombudsman with information that these agencies can be contacted to report actual or potential abuse, neglect, or exploitation of residents or to register complaints concerning the operation of the home. The administrator or operator shall ensure that this information is posted in a common area accessible to all residents and the public. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(k) The facility reported a census of five residents. Based on observation and interview the operator failed to ensure the ombudsman and the department's names, addresses, and telephone numbers were posted in a common area accessible to all residents and the public. Findings included:	S5050		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5050	Continued From page 2 - Observation on 12/17/25 at approximately 11:02 AM during the initial tour revealed the ombudsman and the department's names, addresses, and telephone numbers were not posted in a common area. On 12/17/25 at 12:29 PM during a phone interview Administrative Staff A confirmed the ombudsman and the department's names, addresses, and telephone numbers were not posted in a common area. The operator failed to ensure the ombudsman and the department's names, addresses, and telephone numbers were posted in a common area accessible to all residents and the public.	S5050		
S5080 SS=F	26-42-201 (a) (b) Functional Capacity Screen on Admission (a) On or before each individual ' s admission to a home plus, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the home, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services.	S5080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5080	Continued From page 3 This REQUIREMENT is not met as evidenced by: KAR 26-42-201(a) The facility reported a census of five residents. Based on interview and record review the operator failed to ensure the "Functional Capacity Screen" (FCS) for the Residents included all elements and definitions specified by the department. Findings included: - Record review for Resident (R) 1 revealed an admission date of 09/01/25 with a diagnosis of dementia. The 09/01/25 "FCS" identified R1 was "dependent" for bathing, dressing, toileting, transfers, walking/mobility, and bladder incontinence. He required assistance with eating, had mild cognitive impairment, and was marked at risk for falls, wandering, and behaviors. The 09/01/25 "NSA" identified facility staff assisted R1 with bathing, dressing, toileting, transfers, walking/mobility, and eating. Facility staff administered his medications, provided supervision for cognitive difficulties, and he an indwelling urinary catheter. Services provided R1 for management of treatments, falls, wandering, inappropriate behavior, and catheter care were not described on the "NSA." - Record review for R2 revealed an admission	S5080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5080	Continued From page 4 date of 11/04/25 with diagnoses of dementia, delusions, and agitation. The 11/04/25 "FCS" identified R2 was "dependent" for bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. She had "moderate/severe" cognitive impairment and was marked at risk for falls and behaviors. The 11/04/25 "NSA" identified facility staff assisted R2 with bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. Facility staff administered her medications and provided supervision for cognitive difficulties. Services provided R2 for management of treatments, falls, and inappropriate behavior were not described on the "NSA." - Record review for R3 revealed an admission date of 11/15/25 with diagnoses of dementia and stroke. The 10/28/25 "FCS" identified R3 was "dependent" for bathing, dressing, toileting, transfers, walking/mobility, and bladder incontinence. He required assistance with eating, had mild cognitive impairment, and was marked at risk for falls. The undated "NSA" identified facility staff assisted R3 with bathing, dressing, toileting, transfers, walking/mobility, and eating. Facility staff administered his medications and provided supervision for cognitive difficulties. Services provided R3 for management of treatments and falls were not described on the "NSA."	S5080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5080	Continued From page 5 The facility's "Functional Capacity Assessment" form for all residents, lacked the following elements and definitions with corresponding codes for each residents' ability: Under Section I - Identification Information: lacked items A. Legal name of the resident, C. Primary reason for the screen, and D. Gender Under Section II - Functional Screen: Item A. Activities of Daily Living lacked coding of 0 - independent, 1 - supervision needed, 2 - physical assistance needed, or 3 - unable to perform Under Section II - Functional Screen: lacked item B. Instrumental Activities of Daily Living which included codes to identify the residents' ability for meal preparation, shopping, money management, transportation, use of telephone, laundry and housekeeping, and management of medications and treatments. Under Section II - Functional Screen: lacked item C. Bladder Incontinence which included codes to identify the residents' pattern of bladder control. Under Section II - Functional Screen: lacked item D. Cognition, memory, recall which included codes to identify residents' ability for A. Short-term memory, B. Long-term memory, C. Memory/recall ability, and D. Decision-making ability. Under Section II - Functional Screen lacked item E. Communication which included codes to identify the residents' ability to express	S5080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5080	Continued From page 6 information and their ability to understand others. Lacked Section III - which included codes to identify residents' current or recent problems and risks including falls, impaired vision, impaired hearing, wandering, behaviors, impaired decision-making, and none if they had no issues from that section. Lacked Section IV - which included codes to identify any devices required by the residents to perform activities of daily living. Lacked Section V - which included codes to identify the residents' potential for improved functioning. Lacked Sections VI - Medications, VII - Ordered Therapies and Treatment, VIII - Primary person for legal and financial matters, IX - comments, and X - Participation in the Screen. On 12/18/25 at approximately 10:30 AM Administrative Staff A confirmed the facility's FCS" form failed to include all elements and definitions specified by the department. The undated facility's "Resident Functional Capacity Screening" policy documented a screening would be conducted to determine each individual's functional capacity with findings recorded on a screening form specified by the department or on the facility's own form which included each element and definition specified by the department. The operator failed to ensure the "FCS" form for the residents included all elements and	S5080		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5080	Continued From page 7 definitions specified by the department.	S5080		
S5085 SS=D	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of five residents with three included in the sample. Based on observation, interview, and record review the operator failed to ensure designated staff conducted a "Functional Capacity Screen" (FCS) for Resident (R) 2 following a significant change. Findings included: - Record review for R2 revealed an admission date of 11/04/25 with diagnoses of dementia, delusions, and agitation. The 11/04/25 "FCS" identified R2 was "dependent" for bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. She had "moderate/severe"	S5085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5085	Continued From page 8 cognitive impairment and was marked at risk for falls and behaviors. The 11/04/25 "Negotiated Service Agreement" (NSA) identified facility staff assisted R2 with bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. Facility staff administered her medications and provided supervision for cognitive difficulties. Services provided R2 for management of treatments, falls, and inappropriate behavior were not described on the "NSA." Observation on 12/17/25 at 11:26 AM revealed R2 ambulated independently without difficulty and no devices. She appeared steady on her feet. Staff engaged her in a balloon toss activity. R2 was able to participate from a standing position without losing her balance. On 12/18/25 at approximately 10:30 AM Administrative Staff A stated R2's "FCS" was conducted while she was still in hospital and since moving to the facility her abilities had improved. Administrative Staff A confirmed facility staff had not provided R2 an "FCS" following her significant change. The undated facility's "Resident Functional Capacity Screening" policy documented a screening to determine a resident's capacity would be conducted following any significant change in condition. The operator failed to ensure designated staff conducted a "FCS" for R2 following a significant change.	S5085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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 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) The facility reported a census of five residents. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreements" (NSAs) for Residents (R) 1, R2, and R3 described the services they received based on their "Functional Capacity Screens" (FCSs), needs, and preferences. Findings included: - Record review for R1 revealed an admission date of 09/01/25 with a diagnosis of dementia.	S5105		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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 10 The 09/01/25 "FCS" identified R1 was marked at risk for falls, wandering, and behaviors and he had an indwelling urinary catheter. The "FCS" failed to include R1's capacity to manage treatments. The 09/01/25 "NSA" failed to describe the services R1 received for management of treatments, falls, wandering, inappropriate behavior, and catheter care. - Record review for R2 revealed an admission date of 11/04/25 with diagnoses of dementia, delusions, and agitation. The 11/04/25 "FCS" identified R2 was marked at risk for falls and behaviors. The "FCS" failed to include R2's capacity to manage treatments. The 11/04/25 "NSA" failed to describe the services R2 received for management of treatments, falls, and inappropriate behavior. - Record review for R3 revealed an admission date of 11/15/25 with diagnoses of dementia and stroke. The 10/28/25 "FCS" identified R3 was marked at risk for falls and failed to include his capacity to manage treatments. The undated "NSA" failed to describe the services R3 received for management of treatments and falls. On 12/18/25 at approximately 10:30 AM Administrative Staff A confirmed the "NSAs" for R1, R2, and R3 failed to describe all the services	S5105		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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 11 they received based on their "FCSs." The facility's undated "Negotiated Service Agreement" policy documented the NSAs would include a description of the services the residents received. The operator failed to ensure the "NSAs" for R1, R2, and R3 described the services they received based on their "FCSs," needs, and preferences.	S5105		
S5116 SS=D	26-42-202 (d) NSA revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements: (1) At least once every 365 days;(2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-42-202(d)(2) The facility reported a census of five residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to revise the	S5116		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5116	Continued From page 12 "Negotiated Service Agreement" (NSA) for Resident (R) 2 following a significant change. Findings included: - Record review for R2 revealed an admission date of 11/04/25 with diagnoses of dementia, delusions, and agitation. The 11/04/25 "Functional Capacity Screen" identified R2 was "dependent" for bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. She had "moderate/severe" cognitive impairment and was marked at risk for falls and behaviors. The 11/04/25 "NSA" identified facility staff assisted R2 with bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. Facility staff administered her medications and provided supervision for cognitive difficulties. Services provided R2 for management of treatments, falls, and inappropriate behavior were not described on the "NSA." Observation on 12/17/25 at 11:26 AM revealed R2 ambulated independently without difficulty and no devices. She appeared steady on her feet. Staff engaged her in a balloon toss activity. R2 was able to participate from a standing position without losing her balance. On 12/18/25 at approximately 10:30 AM Administrative Staff A confirmed staff had not provided R2 an "NSA" following her significant change.	S5116		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5116	Continued From page 13 The undated facility's "Negotiated Service Agreement" policy documented the "NSA" was reviewed following any significant change in condition. The operator failed to revise the "NSA" for R2 following a significant change.	S5116			
S5161 SS=F	26-42-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(d) The facility reported a census of five residents. Based on interview and record review the operator failed to ensure each resident's "Negotiated Service Agreements" (NSA) named the licensed nurse responsible for implementing and supervising their "Healthcare Service Plans" (HSP). Findings included: - Record review for R1 revealed an admission date of 09/01/25 with a diagnosis of dementia. The 09/01/25 "FCS" identified R1 was "dependent" for bathing, dressing, toileting,	S5161			

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5161	Continued From page 14 transfers, walking/mobility, and bladder incontinence. He required assistance with eating, had mild cognitive impairment, and was marked at risk for falls, wandering, and behaviors. The 09/01/25 "NSA" identified facility staff assisted R1 with bathing, dressing, toileting, transfers, walking/mobility, and eating. Facility staff administered his medications, provided supervision for cognitive difficulties, and he an indwelling urinary catheter. Services provided R1 for management of treatments, falls, wandering, inappropriate behavior, and catheter care were not described on the "NSA." R1's "NSA" failed to name the licensed nurse responsible for implementing and supervising his "HSP." - Record review for R2 revealed an admission date of 11/04/25 with diagnoses of dementia, delusions, and agitation. The 11/04/25 "FCS" identified R2 was "dependent" for bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. She had "moderate/severe" cognitive impairment and was marked at risk for falls and behaviors. The 11/04/25 "NSA" identified facility staff assisted R2 with bathing, dressing, toileting, transfers, walking/mobility, eating, and bladder incontinence. Facility staff administered her medications and provided supervision for cognitive difficulties. Services provided R2 for management of treatments, falls, and inappropriate behavior were not described on the	S5161		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5161	Continued From page 15 "NSA." R2's "NSA" failed to name the licensed nurse responsible for implementing and supervising her "HSP." - Record review for R3 revealed an admission date of 11/15/25 with diagnoses of dementia and stroke. The 10/28/25 "FCS" identified R3 was "dependent" for bathing, dressing, toileting, transfers, walking/mobility, and bladder incontinence. He required assistance with eating, had mild cognitive impairment, and was marked at risk for falls. The undated "NSA" identified facility staff assisted R3 with bathing, dressing, toileting, transfers, walking/mobility, and eating. Facility staff administered his medications and provided supervision for cognitive difficulties. Services provided R3 for management of treatments and falls were not described on the "NSA." R3's "NSA" failed to name the licensed nurse responsible for implementing and supervising his "HSP." On 12/18/25 at approximately 10:30 AM Administrative Staff A confirmed the "NSAs" for all the residents failed to name the licensed nurse responsible for implementing and supervising their "HSPs." The facility's undated "Negotiated Service Agreement" policy did not address identification of the nurse responsible for supervising and	S5161		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5161	Continued From page 16 implementing the "HSP."	S5161		
S5220 SS=F	26-42-104 (e) Emergency Plan Available (e) Each administrator or operator shall make the emergency management plan available to the staff, residents, and visitors. This REQUIREMENT is not met as evidenced by: KAR 26-42-104(e) The facility reported a census of residents. Based on observation and interview the operator failed to ensure a copy of the emergency management plan was made available to staff, residents, and visitors. Findings included: - On 12/17/25 at approximately 11:00 AM during the initial tour of the facility a copy of the emergency management plan was not located. On 12/17/25 at 11:45 AM Certified Medication Aide (CMA) C stated she could not locate the emergency management plan and would call Administrative Staff A and ask where it was. After a phone call, CMA C confirmed the emergency management plan was unavailable because Administrative Staff A was still working on it. The undated facility's "Disaster and	S5220		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5220	Continued From page 17 Environmental Emergencies" policy documented the safety of residents and employees was a primary concern. Residents and employees were oriented to the emergency management plan at admission and hire and the plan was reviewed every quarter. The operator failed to ensure a copy of the emergency management plan was made available to staff, residents, and visitors.	S5220		
S5380 SS=F	28-39-437 Plumbing and Piping Systems (i) Plumbing and piping systems. (1) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (2) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(i)(2) The facility reported a census of 5 residents. Based on observation and interview the operator failed to ensure designated staff maintained water temperatures within a safe range between 98 degrees Fahrenheit (F) and 120 degrees F. Findings included: - Observation on 12/17/25 at approximately 11:14 AM revealed the water temperature in the	S5380		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: B046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER PARKWAY HOME PLUS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 NALL AVENUE OVERLAND PARK, KS 66207		
(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
S5380	Continued From page 18 main bathroom/shower room was 135.0 degrees Fahrenheit (F). On 12/17/25 at approximately 11:14 AM Certified Nurse Aide (CNA) D stated the facility did not have a water thermometer. Staff checked the water temperature by putting water from the shower on their wrists before residents entered the shower. On 12/17/25 at approximately 12:30 PM Administrative Staff A stated during a phone interview the facility had water thermometer but they did not record the temperatures. Review of the facility's policies and procedures provided during the survey revealed hot water temperature was not addressed The operator failed to ensure designated staff maintained water temperatures within a safe range between 98 degrees F and 120 degrees F.	S5380		