

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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 citations represent the findings of the licensure resurvey with attached complaint numbers 197184, 196934, and 196516, for the above named facility conducted on 02/16/26, 02/17/26, and 02/18/26.	S 000		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility 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: K.A.R.26-41-202 (a) (1) (2) (3) The facility reported a census of 65 residents. The sample included 6 "Residents" (R)'s and 1 focused review. Based on record review and interview, 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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3085	Continued From page 1 "Negotiated Service Agreements" (NSA)'s for R2, R3, R4, R5, and R6 identified the provider of each service and identified each party responsible for payment if an outside resource provided a service. The Administrator further failed to include a description of services on R4's NSA for her pureed diet. Findings included: - Record review for R2 revealed an admission date of 11/26/22 with diagnoses of Alzheimer's disease, coronary artery disease, hypertension, and cognitive impairment. Review of R2's "Functional Capacity Screen" dated 11/13/25 revealed R2 required physical assistance with bathing and dressing. R2 required supervision with eating and toileting. R2 was independent with walking/mobility and transferring. R2 lacked the ability to manage his own medications and was occasionally incontinent. R2 had impaired short-term memory, memory/recall and decision making. R2 was sometimes able to make himself understood and he usually understood others. R2 was identified to be at risk for impaired decision making and used a walker mobility device at times. Review of R2's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 11/13/25 instructed facility staff to assist the local hospice agency with R2's bathing if "they need help", and the local hospice agency would provide all incontinence supplies. R2's combined NSA/HSP lacked the	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3085	Continued From page 2 identification of each party responsible for payment for the outside hospice agency who provided services for R2. - Record review for R3 revealed an admission date of 11/22/24 with diagnoses of Alzheimer's disease, personal history of trans ischemic attack, major depressive disorder, and basal cell carcinoma cancer of the nose. Review of R3's FCS dated 02/20/25 revealed R3 required physical assistance with bathing and dressing. R3 was independent with toileting, transferring, walking/mobility, and she required supervision with eating. R3 lacked the ability to manage her own medications/medical treatments and was frequently incontinent. R3 had impaired short-term memory, memory/recall, and decision making. R3 was at risk for falls, had impaired vision and impaired decision making. Review of R3's combined NSA/HSP dated 02/20/25 instructed facility staff to assist R3 with bathing, dressing, and administer R3's medications and medical treatments. R3's combined NSA/HSP lacked a description of services R3 was to receive from the local hospice agency, identification of the local hospice agency, and the identification of each party responsible for payment when the outside agency provided services. Review of R3's medical record revealed a document titled "Hospice Physician Order" dated 04/21/25 with the order to admit R3 to hospice services for the diagnoses of Cerebral Atherosclerosis.	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3085	Continued From page 3 Review of R3's medical record revealed a document titled "Home Health / Hospice Agency Report" dated 02/18/26 and was signed by the local hospice agency nurse. The note revealed the agency nurse provided wound care to R3's nose and obtained vital signs. Review of the facility provided electronic "Medical Records" "Progress Notes" revealed an entry on 01/31/26 at 10:48 AM that revealed the local hospice agency came and saw R3 and had no new concerns. - Record review for R4 revealed an admission date of 08/02/24 with diagnoses of sleep disorders, heart failure, hypertension, edema, cognitive impairment, and chronic pain. Review of R4's FCS dated 05/13/25 revealed R4 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. R4 lacked the ability to manage her own medications and medical treatments. R4 was continent and her cognition was intact. R4 was able to make herself understood and she understood others. R4 was identified to have poor vision and used a wheelchair mobility device. Review of R4's combined NSA/HSP dated 05/13/25 instructed facility staff to provide a female care giver to assist with bathing twice weekly. Staff were to assist in putting on and taking off R4's compression stockings daily, administer R4's medications, provide reminders at mealtimes and R4 ate a regular diet.	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3085	Continued From page 4 R4's combined NSA/HSP lacked a description of services R4 was to receive from the local hospice agency, identification of the local hospice agency, and the identification of each party responsible for payment when the outside agency provided services. Review of R4's medical records revealed a document titled "Telephone Orders" signed by R4's primary care provider on 12/08/25 that ordered the facility staff to "Puree meat and all non-soft foods". R4's combined NSA/HSP lacked identification that the facility would provide the service of following the medical providers order to puree R4's meat and all non-soft foods. Review of R4's medical record revealed a document titled "Home Health / Hospice Agency Report" dated 02/16/26 and it was documented that the services provided were for an occupational therapy revisit. Review of R4's medical record revealed a document titled "Home Health / Hospice Agency Report" dated 02/09/26 and it was documented that the services were for wound care to R4's coccyx. - Record review for R5 revealed an admission date of 08/28/23 with diagnoses of mild cognitive impairment, history of cerebral vascular accident, and anxiety disorder. Review of R5's FCS dated 12/04/25 revealed R5 required physical assistance with bathing, dressing, toileting, transferring, walking/mobility,	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3085	Continued From page 5 and eating. R5 lacked the ability to manage her own medications and medical treatments. R5 was frequently incontinent, and had impaired short-term memory, memory/recall, and decision making. R5 was identified to have impaired vision and at risk for impaired decision making. R5 required a mechanical lift. No mobility device was identified. Review of R5's combined NSA/HSP instructed facility staff that the local hospice agency would provide R5 two bed baths per week. Facility staff were instructed to assist R5 with dressing daily, assist R5 with meals, and toileting. Facility staff were instructed that the local hospice agency would provide R5's incontinence products. R5's combined NSA/HSP lacked identification of the local hospice agency providing services, and the combined NSA/HSP further lacked identification of each party responsible for payment when an outside resource provided a service. - Record review for R6 revealed an admission date of 09/21/21 with diagnoses of metabolic encephalopathy, muscle weakness, and dementia. Review of R6's FCS dated 12/30/25 revealed R6 required physical assistance with bathing, dressing, toileting, and walking/mobility. R6 required supervision with transferring and eating. R6 lacked the ability to manage her own medications and was frequently incontinent. R6 had impaired short-term memory, long-term memory, memory recall, and decision making. R6 was usually able to make herself understood and	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3085	Continued From page 6 she usually understood others. R6 was identified at risk for falls, impaired vision, wandering, socially inappropriate behavior, and impaired decision making. Review of R6's combined NSA/HSP dated 12/30/25 instructed facility staff to assist R6 with dressing, and toileting. The local hospice agency would provide R6 with showers twice a week and facility staff would assist with showers as needed. Staff were instructed to propel R6's wheelchair to the dining room for meals. Under the section titled "Falls" it was handwritten that R6 was a high fall risk, and she may try to transfer herself. The local hospice agency had provided a "high-low" bed and "fall mats". R6's combined NSA/HSP lacked identification of each party responsible for payment when an outside resource provided a service. Interview on 02/18/26 with "Licensed Nurse" (LN) A, LN B, and Administrator D confirmed the NSA's for R's 2, 3, 4, 5, and 6 lacked the identification of the outside providers, the identification of the payor source when the outside provider provided a service, and the lack of a description of dietary services for R4's pureed diet. The Administrator failed to ensure the NSA's for R2, R3, R4, R5, and R6 identified the provider of each service and identified each party responsible for payment if an outside resource provided a service. The Administrator further failed to include a description of services on R4's NSA for her pureed diet.	S3085		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3171	Continued From page 7	S3171		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-204 (i) The facility reported a census of 65 residents. The sample included 6 "Residents" (R)'s and 1 focused review. Based on observation, interview and record review, the Administrator failed to ensure health care services were provided within professional standards of practice when the Administrator failed to ensure an assessment was performed for R4 and R6 that showed the bed assist devices posed no risk for entrapment, confirmed the devices were not a restraint, and R4 and R6's ability to safely used the bed assist devices. Findings included: - Record review for R4 revealed an admission date of 08/02/24 with diagnoses of sleep disorders, heart failure, hypertension, edema, cognitive impairment, and chronic pain. Review of R4's "Functional Capacity Screen" (FCS) dated 05/13/25 revealed R4 was independent with bathing, dressing, toileting, transferring, walking/mobility, and eating. R4	S3171		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3171	Continued From page 8 lacked the ability to manage her own medications and medical treatments. R4 was continent and her cognition was intact. R4 was able to make herself understood and she understood others. R4 was identified to have poor vision and used a wheelchair mobility device. Review of R4's combined "Negotiated Service Agreement" (NSA) / "Health Service Plan" (HSP) dated 05/13/25 instructed facility staff to provide a female care giver to assist with bathing twice weekly. Staff were to assist in putting on and taking off R4's compression stockings daily, administer R4's medications, provide reminders at mealtimes and use her call pendant if she needed assistance. Observation on 02/18/26 at approximately 01:00 PM of R4's bed revealed the head of the bed was in the northwest corner of the room and the foot of the bed was to the east. On the southwest side of the bed was an inverted "U" shaped device that measured approximately 14 inches from the outside of each leg of the "U" shaped device, and approximately 31 inches from the top of the device to the end of the legs of the device that rested on the floor. The device slid under the mattress of the bed. The open space of the inverted "U" shaped device measured approximately 12 inches by 14 inches. The device freely moved from underneath the mattress. Interview on 02/18/26 at approximately 01:00 PM with R4 confirmed she used the bed assist device to get into and out of her bed. R4's medical record lacked documentation of an	S3171		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3171	Continued From page 9 assessment for R4 that showed the bed assist device posed no risk for entrapment, confirmed the device was not a restraint, and R4's ability to safely use the bed assist device. R4's NSA/HSP lacked a description of the device, its purpose and special instructions on use and monitoring in the R4's NSA/HSP. - Record review for R6 revealed an admission date of 09/21/21 with diagnoses of metabolic encephalopathy, muscle weakness, and dementia. Review of R6's FCS dated 12/30/25 revealed R6 required physical assistance with bathing, dressing, toileting, and walking/mobility. R6 required supervision with transferring and eating. R6 lacked the ability to manage her own medications and was frequently incontinent. R6 had impaired short-term memory, long-term memory, memory recall, and decision making. R6 was usually able to make herself understood and she usually understood others. R6 was identified at risk for falls, impaired vision, wandering, socially inappropriate behavior, and impaired decision making. Review of R6's combined NSA/HSP dated 12/30/25 instructed facility staff to assist R6 with dressing, and toileting. The local hospice agency would provide R6 with a shower twice a week, and facility staff would assist R6 with showers as needed. Staff were instructed to propel R6's wheelchair to the dining room for meals. Under the section titled "Falls" it was handwritten that R6 was a high fall risk, and she may try to transfer herself. The local hospice agency had	S3171		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3171	Continued From page 10 provided a "high-low" bed and "fall mats". R6's medical record lacked documentation of an assessment for R6 that showed the bed assist devices posed no risk for entrapment, confirmed the devices were not a restraint, and R6's ability to safely use the bed assist devices. R6's NSA/HSP lacked a description of the device, its purpose and special instructions on use and monitoring in the R6's NSA/HSP. Observation on 02/18/26 at approximately 11:45 AM of R6's bed revealed the head of the bed was in the southeast corner of the room and the foot of the bed was towards the southwest of the room. On each side of the bed were circular-shaped bed assistive devices that measured approximately 12 inches in diameter. The device's inner diameter lacked any opening greater than 4 and 3/4 inches. The device had a single pole that measured approximately 4 inches in length and was attached securely to the bedframe. Interview on 02/18/26 at approximately 03:00 PM with "Licensed Nurse" (LN) A, LN B, and Administrator D confirmed the medical records for R's 4 and 6 lacked documentation of an assessment being performed that showed the bed assist devices posed no risk for entrapment, confirmed the devices were not a restraint, and R4 and R6's ability to safely used the bed assist devices. The FDA (food and drug administration) "Bedrails in Assisted Living, Residential Health Care and Home Plus Facilities" recommended	S3171		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3171	Continued From page 11 the following: Complete an assessment of the resident to confirm that the device is not a restraint. Complete an assessment of the resident to determine the purpose of the device and the resident's ability to safely use the device and document the findings in the resident's record. Complete an assessment of the device using the recommendations in the FDA guidance to ensure the device is securely attached to the bed or bedframe and poses no risk for entrapment and document the findings in the resident record. If the purpose of the device is to assist the resident with transfers, the FCS should document the resident's functional capacity based on the use of the device and should be listed in the comments section. Include a description of the device, its purpose and special instructions on use and monitoring in the resident's NSA. Document periodic reassessments of the resident's use of the device and their ability to use it safely and reassessment of the safety of the device in the resident's record. The Administrator failed to ensure health care services were provided within professional standards of practice when the Administrator failed to ensure an assessment was performed for R4 and R6 that showed the bed assist devices posed no risk for entrapment, confirmed the devices were not a restraint, and R4 and	S3171		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3171	Continued From page 12 R6's ability to safely used the bed assist devices.	S3171		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-104 (d) (3) The facility reported a census of 65 residents. Based on record review and interview the Administrator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan with employees and residents. Findings included:	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3280	Continued From page 13 - Review of the facility provided document titled "Sign In", and in the "Subject" line it was handwritten "Emergency Response Manual" and dated 09/25/25 revealed 12 residents signed in for the training. Review of the facility provided document titled "Sign In", and in the "Subject" line it was handwritten Emergency Preparedness Manual and dated 09/26/25 revealed 17 employees attended the training. Review of the facility provided untitled and undated document revealed that 17 staff members had been "Presented the Emergency Response Plan and it had been reviewed" with the employees. Review of the facility provided document titled "Sign In", and in the "Subject" line it was handwritten "Emergency Response Plan" Assisted Living Residents, dated 12/23/25 revealed 13 residents attended the training. Review of the facility provided document titled "Sign In", and in the "Subject" line it was handwritten "Emergency Response Manuel" Memory Care residents dated 12/22/25 revealed 11 residents received the training. Review of the facility provided binder titled "Resident Council" revealed the following; On 06/26/25 Maintenance Director C reviewed the Emergency Plan of Tornado and Fire instructions. 11 residents were marked in attendance of the resident council meeting.	S3280		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3280	Continued From page 14 On 09/25/25 Maintenance Director C did a review of the emergency response plan and informed the residents that the Emergency Response Plan book was located at the front desk for residents to review. 12 residents were marked in attendance of the resident council meeting. Review of the facility provided undated policy titled Emergency Preparedness revealed the "Purpose" of the policy was "to ensure the safety and protection of residents, staff and visitors during emergencies" in accordance with the departments regulations. Under the section titled "Emergency Plan" it revealed "A written Emergency Preparedness Plan shall be maintained and reviewed annually". Interview on 02/18/26 at approximately 03:00 PM with Administrator D and Maintenance Director C confirmed the Emergency Preparedness Plan was not reviewed with staff and residents quarterly. They further confirmed if the residents did not come to the meetings the residents did not receive the Emergency Preparedness training. The Administrator failed to ensure disaster and emergency preparedness by ensuring a quarterly review of the facility's emergency management plan with employees and residents.	S3280		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care	S3305		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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 15 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 health of other residents. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207 (b) (4)	S3305		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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 The facility reported a census of 65 residents. Based on record review and interview, the Administrator failed to ensure the facility provided sanitary conditions for food service. Findings included: - Observation on 02/16/26 at approximately 01:00 PM of the facility dishwashing area revealed on the east wall sat a wire rack. On the rack was a small plastic container that held 3 ribbons of "Parts Per Millon" (PPM) chemical test strips, the dietary staff washing the dishes confirmed she did not perform the chemical test on the dish solution. Interview on 02/17/26 with Dietary Director E confirmed the dishwasher temperature reached 120 degrees Fahrenheit, and the sanitation was a chemical process. He continued to confirm the dishwasher had recently been rebuilt and that there had not been a consistent process of testing the PPM to ensure the chemical was within sanitation range and there was not a daily log for review. Review of the facility provided undated policy titled "Dishwasher Sanitation and Kitchen Ware Cleaning" revealed the following; "Purpose: To ensure all dishes, utensils, and food service equipment are properly cleaned and sanitized" in accordance with the departments regulations and applicable food safety standards. Under the section titled "Mechanical Dishwasher Use" it revealed "If chemical sanitizer is used, proper concentration must be maintained" and	S3305		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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 17 "Temperature or Sanitizer logs shall be maintained". The Administrator failed to ensure the facility provided sanitary conditions for food service.	S3305		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (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; (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 (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 This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-207 (c) The facility reported a census of 65 residents. The sample included 6 "Residents", 1 focused review, and 5 newly hired employees. Based on record review and interview the Administrator failed to ensure the facilities compliance with the departments "Tuberculosis" (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired "Certified Nurse Aide"	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3310	Continued From page 18 (CNA) F. Findings included: - Record review for CNA F revealed he began his employment on 11/07/25. Review of CNA F's personnel record revealed a document titled "Tuberculin Skin Test" dated 06/23/25. Step one of the required TB skin test was implanted on 6/23/25 and read on 06/25/25 with a result of "Negative 10 millimeter induration" with a history of receiving the "Bacille Calmette-Guerin" (BCG) vaccine". The test was signed with an unreadable signature and "Certified Medication Aide" (CMA) written after the signature. - CNA F's personnel file lacked documentation of the required one step TB skin test within 7 days of hire. - Review of the facility provided undated policy titled "Tuberculosis (TB) Screening and Control" revealed the following: "The facility shall implement TB screening and infection control measures for employees and residents as required by state regulation and public health authorities", "Screening may include a TB skin test (TST), blood assay or documentation of prior testing. Positive test results required medial evaluation and chest x-ray documentation". - Interview on 02/19/26 at approximately 03:00 PM with "Licensed Nurse" (LN) B confirmed CNA F's personnel record lacked documentation of a chest x-ray or a one step TB skin test within	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3310	Continued From page 19 seven days of being hired. The Administrator failed to ensure the facilities compliance with the departments TB guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 for newly hired CNA F.	S3310		
S3320 SS=E	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26, 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: K.A.R. 28-39-254 (a)	S3320		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3320	Continued From page 20 The facility reported a census of 65 residents. 17 Residents resided in the secured specialty unit. Based on observation and interview the Administrator failed to ensure the secured specialty unit of the facility was maintained to protect the health and safety of the 17 residents who resided in the unit. Findings included: - Observation on 02/18/26 at approximately 11:40 AM with "Licensed Nurse" LN A in the secured specialty unit, revealed an open apartment door. A counter was on the north side of the wall when you walked into the apartment. On the right side of the counter sat a large container of Lysol laundry sanitizer and a large bag of Arm and Hammer laundry pods. On the left side of the counter was a container of Clorox disinfectant wipes. Above the counter where the sink was located a cabinet door freely opened and revealed a container of Nail polish remover and a container of Clorox disinfectant wipes. In the lower cabinets on the left side the door freely opened and revealed three containers of Clorox disinfectant wipes. In the bathroom on the south wall sat a small set of black wire shelves, and on the bottom shelf were a large bag of Arm and Hammer laundry pods. In the small closet located on the north wall of the apartment the door freely opened and on the floor was a bottle of Clorox toilet bowl cleaner, a spray bottle of Scrubbing Bubbles cleaner, and a box of Clorox toilet wand refills. Interview on 02/18/26 at approximately 03:00 PM	S3320		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S3320	Continued From page 21 with LN A, LN B, and Administrator D confirmed all chemicals were to be secured in the facilities secured specialty unit. The Administrator failed to ensure the secured specialty unit of the facility was maintained to protect the health and safety of the 17 residents who resided in the unit.	S3320		
S9999	Final Observations K.S.A. 39-928 Upon receipt of an application for license, the licensing agency with the approval of the state fire marshal shall issue a license if the applicant is fit and qualified and if the adult care home facilities meet the requirements established under this law. A license, unless sooner suspended or revoked, shall remain in effect upon filing by the licensee, and approval by the licensing agency and the state fire marshal or their duly authorized agents, of an annual report upon such uniform dates and containing such information in such form as the licensing agency prescribes and payment of an annual fee. S/S level F Findings included: - Department records revealed the facility failed to file and pay the 2023, 2024, and 2025 annual renewal licensing fees. Review of the facility provided printed electronic mail dated 09/08/25 "Annual Renewal Application	S9999		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS AT LEAWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 W 143RD STREET OVERLAND PARK, KS 66224		
(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
S9999	Continued From page 22 Notification" revealed the department had received application number 6698 and it had been received, reviewed, and approved. The Notification lacked a date for the renewal. Interview on 02/19/26 at approximately 03:00 PM with Administrator D confirmed the facility's failure to pay the renewal fee to the department for 2024 and 2025. The facility failed to file and pay the 2023, 2024 and 2025 annual renewal licensing fee to the department as required by KSA 39- 928.	S9999		