

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 6921 W. 81ST STREET OVERLAND PARK, KS 66204		
(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 abbreviated survey with review of facility report 198018, 198007, 198324, 198745 at the above assisted living conducted on 05/11/26-05/12/26.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 63 residents with three focused record reviews and one closed record review. Based on observation, interview, and record review the administrator failed to protect cognitively impaired Resident (R)1 from neglect when he exited the building through an alarmed door. Local police received a phone call from a nearby convenience store indicating R1 was there, the police picked up R1 and brought him back to the facility at approximately 07:30 PM. R1 was out of facility and unattended for approximately 6.25 hours in a busy, urban area. This failure placed R1 in Immediate Jeopardy.	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 10/09/24 with diagnoses of restlessness, agitation, and Alzheimer's disease. The 11/03/25 Functional Capacity Screen (FCS) identified R1 needed physical assistance with bathing, dressing, toileting, transfers, and walking/mobility, was unable to perform management of medications and treatments, and needed supervision with eating. R1 used a wheelchair to perform activities of daily living, he had short-term and long-term memory, memory recall, and decision-making difficulties. R1 usually understood and was usually understandable during communication and he was at risk for falls. The 11/03/25 "Service Agreement" is the facility's combined Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) which indicated staff provided reminders and assistance to events and meals, encouraged activities of choice, and ensured he was using a wheelchair for mobility. R1 required oversight, cueing, and encouragement at mealtimes and was to be assisted to toilet every two to three hours. The NSA/HSP was revised on 01/01/26 for safety checks indicating staff completed safety and care checks every two hours. Review of the "Meal Consumption Tracking Report" for the month of February 2025 revealed R1's meal intake for the 02/08/26 evening meal was not recorded.	S3026		

Kansas Department on Aging

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S3026	Continued From page 2 The 02/09/26 at 04:41 PM "Elopement" note by Licensed Nurse (LN) C documented R1 was returned to the facility at 07:30 PM by the local police department. LN C went to the local convenience store and talked to management who told him R1 was in the store for approximately ten minutes trying to get to a previously known address and then walked around the parking lot until the police arrived. The 02/09/26 "Intake Information" emailed to the State Agency reported R1 was seen on facility cameras leaving the facility unattended at 01:15 PM without indicating a date. The report indicated upon return R1 was placed on every 15-minute checks, which were ongoing at the time of the report. The report indicated R1 had been at the local convenience store and at a liquor store. R1 was also seen walking around inside a parking garage near the facility. A full investigation was requested from the facility on 05/11/26 at 11:50 AM including notarized staff witness statements, R1's FCS, NSA/HSP from before and after the elopement, elopement risk forms for before and after the elopement, and nurses' notes which the facility failed to provide. On 05/11/26 at 02:15 PM Administrative Staff A provided a signed document dated 02/13/26 which documented the Human Resource Manager and himself had reviewed facility cameras without identifying a date and time. The camera footage showed R1 had disengaged the front door's alarm by pressing in on the latch and pushing on the door without pushing the door's bar.	S3026		

Kansas Department on Aging

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S3026	Continued From page 3 Review of the facility's "Resident Roster" provided during the survey revealed two residents were at risk for wandering. Review of staff schedule and invoices from a local staffing agency for 02/08/26 revealed the morning shift included four facility caregivers and five temporary Certified Nurse Aides (CNAs). The evening shift had two facility caregivers and four temporary CNAs. On 05/12/26 at 04:02 PM every 15-minute safety checks were requested as mentioned in the "intake" information sent to the department on 02/09/26 which the facility failed to provide. Observation on 05/12/26 at 11:05 AM revealed a possible route R1 took from his room to exit the building. From his room to the front door was approximately 60 steps. The front door had a keypad lock on the wall beside the door and push bar, which sounded an alarm when pushed. Observation on 05/12/26 at 11:10 AM revealed a convenience store where police found R1, the parking garage where R1 was seen wandering, and the local roads he would have traveled. R1 would have walked approximately 240 feet through the facility parking lot, across a two lane, 25 miles per hour (mph) street to a parking garage. The road in front of the parking garage and convenience store was a four-lane street with a speed limit of 40 mph. R1 would have walked approximately 300 feet through or around the parking garage and uphill to the convenience store. Local liquor stores were located 0.4 miles south or 0.2 miles northwest which both include crossing intersections with stoplights and no	S3026		

Kansas Department on Aging

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S3026	Continued From page 4 crosswalks. The stoplights required pushing a button for traffic to stop in order to safely cross. The neighborhood was urban with busy streets and businesses. The weather on 02/08/26 at 02:53 PM according to Wunderground.com was 63 degrees Fahrenheit (F) with a wind speed of 10 mph, at 06:53 PM it was 60 degrees F with five mph wind and dark. The sun set at 05:49 PM. On 05/11/26 at 12:08 PM Administrative Staff A explained what he saw on the cameras and showed the pieces of the door latch where R1 was able to push and get the alarm to not sound while opening door. On 05/12/26 at 01:08 PM Administrative Nurse B stated, R1 was a "going to get out person," R2 wandered aimlessly, R5 wandered looking for her son, R6 wandered "real bad," and R7 wandered in and out of open doors. She confirmed the resident roster had not been updated recently and was noted with only two residents marked for wandering and stated there should be at least five to six wandering residents identified on the roster. On 05/12/26 at 11:35 AM Administrative Nurse B confirmed normal staffing for day and evening shifts were seven CNAs and the majority of staff on 02/08/26 were agency staff. On 05/12/26 at 12:28 PM Certified Medication Aide D stated she was on duty the day R1 got out of the facility. She was unaware he was gone. She stated it would have been the CNAs duty to make sure his care plan was followed.	S3026		

Kansas Department on Aging

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S3026	Continued From page 5 On 05/12/26 at 01:33 PM Administrative Staff G stated when the camera recordings were reviewed Administrative Staff A and G saw a visitor of the facility also manipulate the alarmed door to not alarm when they exited. On 05/12/26 at 02:15 PM R1 stated he went out of the facility every day. The name of the local convenience store was familiar to him and he said it is on the main street but he was not sure the name of the "main street." R1 stated he did not need to let anyone know if he left the building. R1 could not recall events that occurred on 02/08/26. On 05/12/26 at 02:22 PM Therapy Staff F stated R1 knew where he was going 75% of the time and got turned around the other 25% of the time. On 05/12/26 at 04:00 PM Administrative Nurse B confirmed the facility lacked documentation or proof a staff member sat at the front door from the time of R1's return to the facility until 02/10/26 when an additional bar guard was placed on the door latch, which prevented manipulation of the door alarm. On 05/12/26 at 04:09 PM Administrative Nurse B stated the day after the elopement R1 told her he "had the time of his life" but was unable to say what he did or where he went. The facility's 03/2016 "Elopement/Missing Resident" policy documented elopement precautions are carried out for resident safety. Staff were to remain alert and redirect residents near exit areas, staff were routinely notified of	S3026		

Kansas Department on Aging

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S3026	Continued From page 6 residents at risk, service plans reflected interventions for resident safety, and routine safety checks were made. The administrator failed to protect cognitively impaired R1 from neglect when unknown to staff, he exited the building through an alarmed door and wandered approximately 0.4 miles through the busy urban neighborhood unattended for approximately 6.25 hours. On 05/12/26 the facility's removal plan was accepted by the department at 04:52 PM. The plan included the following interventions: 1) The lobby door had bar guard installed on 02/10/26 2) All visitors were given "visitor" tags starting on 02/09/26 3) All doors were checked by maintenance, administration, and clinical staff at least twice a week 4) All doors were checked by an outside vendor at least quarterly and are utilized when doors were found defective 5) All staff were educated regarding what to do when they discovered a resident may be missing on 02/09/26	S3026		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements	S3028		

Kansas Department on Aging

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S3028	Continued From page 7 are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(C) The facility reported a census of 63 residents with three focused record reviews and one closed record review. Based on interview and record review the administrator failed to complete and submit investigation within five working days of an initial report to the department when Resident (R) 2 and R3 each exited through an unsecured door on separate occasions.	S3028		

Kansas Department on Aging

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S3028	Continued From page 8 Findings included: - Record review for R1 revealed an admission date of 10/09/24 with diagnoses of restlessness, agitation, and Alzheimer's disease. The 11/03/25 Functional Capacity Screen (FCS) identified R1 needed physical assistance with bathing, dressing, toileting, transfers, and walking/mobility; was unable to perform management of medications and treatments; and needed supervision with eating. R1 used a wheelchair to perform activities of daily living; he had short-term and long-term memory, memory recall, and decision-making difficulties; he usually understood and was usually understandable during communication; and he was at risk for falls. The 11/03/25 "Service Agreement" is the facility's combined Negotiated Service Agreement/Healthcare Service Plan (NSA/HSP) which indicated staff provided reminders and assistance to events and meals, encouraged activities of choice, and ensured he was using a wheelchair for mobility. R1 required oversight, cueing, and encouragement at mealtimes and was to be assisted to toilet every two to three hours. The NSA/HSP was revised on 01/01/26 for safety checks indicating staff completed safety and care checks every two hours. The 02/09/26 "Intake Information" emailed to the department reported R1 was seen on facility cameras to have left the facility at 01:15 PM without indicating a date. R1 was out of the community unattended for at least six hours.	S3028		

Kansas Department on Aging

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S3028	Continued From page 9 The facility's investigation and follow up of the incident was requested on 05/11/26 at approximately 11:50 AM. On 05/11/26 at approximately 02:15 PM Administrative Staff A provided a signed document dated 02/13/26 with the intake information word-for-word with additional information of camera review and R1 being dressed appropriately for the weather. An additional piece was installed to the door, receptionist staff were trained on keeping desk attended and monitoring visitors. The document failed to include attachments with any further documentation including witness statements, training provided to staff, or resident information. - Record review for R2 revealed an admission date of 02/04/26 with a diagnosis of Alzheimer's. The 03/09/26 FCS identified R2 was unable to perform management of medications and treatments; required physical assistance with bathing; required supervision with dressing, toileting, and eating; was independent with transfers and mobility; had short-term memory, long-term memory, memory/recall, and decision-making cognitive difficulties; usually understood others and sometimes was understandable during communication; and was at risk for wandering. The 03/09/26 NSA/HSP identified facility staff completed safety checks on R2 every two hours, redirected R2 and encouraged involvement in activities, and monitored R2's whereabouts in the facility.	S3028		

Kansas Department on Aging

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S3028	Continued From page 10 The 05/01/26 "Intake Information" documented R2 left the building on 04/24/26 at 12:55 PM out the door in the 200 hall and walked around the building to the parking lot on the back side of the building. The facility's investigation and follow up of the incident was requested on 05/11/26 at approximately 11:50 AM. On 05/11/26 at approximately 02:15 PM Administrative Staff A provided a signed document dated 05/05/26 with the intake information word-for-word with two sentences indicating the resident was only out of the building for a few minutes and was dressed appropriately. The document failed to include any attachments with further documentation including witness statements, training provided to staff, or resident information. - Record review for R3 revealed an admission date of 02/23/26 with a diagnosis of head injury. The 03/19/26 FCS identified R3 was unable to perform management of medications and treatments; required physical assistance with bathing, dressing, toileting, transfers, and mobility; had short-term memory and decision-making cognitive difficulties; usually understood others and usually was understandable during communication; and was at risk for falls and impaired decision making. The 03/19/26 NSA/HSP identified facility staff assisted R3 with day-to-day decisions and completed safety checks every two hours. The	S3028		

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S3028	Continued From page 11 NSA/HSP indicated R3 made decisions harmful or potentially harmful to himself. Staff of one to two assisted R3 with ambulation. The 03/17/26 "Intake Information" documented R3 left the building out the door in the 200 hall and walked around the building to the activity room. The report indicated the staff were trained and retrained on the alarm system weekly. Certified Medication Aide H saw the resident and assisted back inside. The facility's investigation and follow up of the incident was requested on 05/11/26 at approximately 11:50 AM. On 05/11/26 at approximately 02:15 PM Administrative Staff A provided a signed document dated 05/05/26 with the intake information word-for-word with one sentence at the end indicating the facility contracted a vendor to check all doors quarterly. The document failed to include any further documentation including witness statements, training provided to staff, or resident information. - Record review for R4 revealed an admission date of 05/30/24 with a diagnosis of dementia. The 12/19/25 FCS identified R4 was unable to perform management of medications and treatments. The 03/19/26 NSA/HSP identified facility CMA or licensed nurse administered R4's medications. The 02/09/26 "Intake Information" documented R4 received morphine sulfate every two hours	S3028		

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S3028	Continued From page 12 scheduled when the pharmacy input the medication into the electronic medical record incorrectly. The facility's investigation and follow up of the incident was requested on 05/11/26 at approximately 11:50 AM. On 05/11/26 at 12:34 PM Administrative Nurse B provided a "Resident Incident Report" dated 02/05/26 which indicated the system follow up was "hospice notified" and "reviewed at manager meeting." The report failed to include any further documentation including witness statements, training provided to staff, or resident information. On 05/11/26 at approximately 02:25 PM Administrative Staff A confirmed he had not submitted any investigation documentation to the state department for the four incidents reported since last survey. The administrator failed to complete and submit investigation within five working days of an initial report to the department when R2 and R3 each exited through an unsecured door on separate occasions.	S3028		
S3320 SS=H	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	S3320		

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S3320	Continued From page 13 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: KAR 28-39-254(a) The facility reported a census of 63 residents. Based on record review and interview, the administrator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring all door alarms were maintained and properly used at all times which had the potential to affect all residents. Findings included: - Review of "Resident Roster" provided by the facility on 05/11/26 during entrance revealed 63 residents with impaired cognition. - Record review for R2 revealed an admission date of 02/04/26 with a diagnosis of Alzheimer's.	S3320		

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S3320	Continued From page 14 The 03/09/26 FCS identified R2 was unable to perform management of medications and treatments; required physical assistance with bathing; required supervision with dressing, toileting, and eating; was independent with transfers and mobility; had short-term memory, long-term memory, memory/recall, and decision-making cognitive difficulties; usually understood others and sometimes was understandable during communication; and was at risk for wandering. The 03/09/26 NSA/HSP identified facility staff completed safety checks on R2 every two hours, redirected R2 and encouraged involvement in activities, and monitored R2's whereabouts in the facility. The 05/01/26 "Intake Information" documented R2 left the building on 04/24/26 at 12:55 PM out the door in the 200 hall and walked around the building to the parking lot on the back side of the building. After investigating, a staff member had responded to a prior alarm and failed to properly reset the door alarm. On 05/11/26 at approximately 02:15 PM Administrative Staff A confirmed staff did not properly set the door alarm on 04/24/26 allowing R2 to walk out without notification. - Record review for R3 revealed an admission date of 02/23/26 with a diagnosis of head injury. The 03/19/26 FCS identified R3 was unable to perform management of medications and treatments; required physical assistance with	S3320		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/12/2026
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S3320	Continued From page 15 bathing, dressing, toileting, transfers, and mobility; had short-term memory and decision-making cognitive difficulties; usually understood others and usually was understandable during communication; and was at risk for falls and impaired decision making. The 03/19/26 NSA/HSP identified facility staff assisted R3 with day-to-day decisions and completed safety checks every two hours. The NSA/HSP indicated R3 made decisions harmful or potentially harmful to himself. Staff of one to two assisted R3 with ambulation. The 03/17/26 "Intake Information" documented R3 left the building out the door in the 200 hall and walked around the building to the activity room. The report indicated the door light was flashing which indicated a staff member had disarmed the door prior. On 05/11/26 at approximately 02:15 PM Administrative Staff A confirmed staff did not properly set the door alarm on 03/16/26 allowing R3 to walk out without staff knowing. The administrator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring all door alarms were properly used at all times which had the potential to affect all residents.	S3320		