

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175180		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/14/2026	
NAME OF PROVIDER OR SUPPLIER OVERLAND PARK POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5211 W 103RD STREET , OVERLAND PARK, Kansas, 66207			
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F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigations 3054509, 3055304, 3053186, and 3053524. The census was 140. The sample included six residents.			F0000			
F0726 SS = E	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			F0726			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0726 SS = E	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure staff possessed the appropriate skills and knowledge to safely provide direct care and nursing services related to Resident (R) 1's care needs. Findings included: - A "Medication Error report # 648" completed on 06/11/2026 at 09:35 PM by Licensed Nurse (LN) G documented R1 received the wrong medication from Certified Medication Aide (CMA) R. R1 was scheduled to received glargine (a long-acting insulin (hormone that lowers the level of glucose in the blood) used to manage blood sugar in type 1 and type 2 diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) , providing a steady insulin level for up to 24 hours) 65 units (U), but CMA R administered Novolog (a rapid-acting insulin used to control blood sugar in adults and children with DM, typically taken five to ten minutes before meals) 45 U as CMA R reported. The immediate actions taken for R1 included assessing R1 who was documented to be alert and oriented at that time. The event was reported to Consultant GG and Administrative Nurse D. R1's "Orders" tab documented the following physician orders for insulin: Basaglar Kwik Pen solution pen-injector 100 units/ML (insulin Glargine) inject 65 U's subcutaneously (beneath the skin) at bedtime related to Type 1 DM without complications, hold for blood sugar less than 70 mmol/L or unable to eat. Notify the medical director if blood sugar is less than 70 mmol/L or more than 400 mmol/L, ordered on 04/07/2026. Novolog Flex Pen solution pen-injector 100 units/ML (insulin Aspart) inject 20 U's subcutaneously three times a day related to Type 1 DM without complications, hold for blood sugar less then 70 or unable to eat. Notify the medical director if blood sugar is less than 70 mmol/L or more than 400 mmol/L, ordered on 03/22/2023 On 06/11/2026 at approximately 08:00 PM, Certified			F0726			

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F0726 SS = E	Continued from page 2 Medication Aide (CMA) R's written statement documented CMA R took R1's blood sugar and proceeded to dial up her insulin. CMA R simply misread the order on the screen and grabbed the wrong insulin pen. CMA R documented the dose for 65 U and that is what CMA R dialed up in the pen. CMA R then injected R1 with the pen. CMA R documented that R1 did not get the entire amount, due to CMA R stopping the injection after realizing it was the wrong insulin pen. CMA R documented approximately more than half of the 65 U's were injected. CMA R dialed the remainder back into the pen and alerted the nurse. On 07/14/2026 at 12:52 PM, CMA R stated that LN G had instructed her to take the carts and pass the medications. CMA R stated she had asked if that meant the insulins and reported that LN G indicated to take one of the carts and do it pointing at the cart that CMA R reported had the insulins in it. On 07/13/2026 at 02:18 PM, LN H stated "No," a CMA could not administer insulin to a resident. Only a nurse could do that, but if a resident had an order to self-administer, LN H thought a CMA could dial up the insulin and hand it to a resident for the resident to administer it themselves. On 07/14/2026 at 11:20 AM, LN G was unable to be reached via phone. On 07/13/2026 at 02:05 PM, Administrative Nurse D stated that when she found out about the medication error, she interviewed CMA R and let her know that this was not Missouri, and she could not administer insulin in this state. Administrative Nurse D further revealed that CMA R then informed Administrative Nurse D that she had given insulin in the facility in the past. Administrative Nurse D stated CMA R had been put as do not return (DNR) to the facility, as CMA R was an agency staff member. Administrative Nurse D provided a typed-up statement of the phone call that she reportedly had with CMA R, while handing over the typed statement, Administrative Nurse D revealed that she had just typed it up today (07/13/2026). The statement read: On 06/11/25, Administrative Nurse D spoke with CMA R on the phone regarding the insulin medication error that occurred with R1. Education was provided to CMA R that CMA's could not administer insulin in Kansas, despite their training. CMA R verbalized understanding and stated that it would not happen	F0726					

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F0726 SS = E	Continued from page 3 again. CMA R was prohibited from returning to the facility at that time. On 07/14/2026 at 01:50 PM, Administrative Nurse D stated that LN G was an employee of the facility and that she educated LN G that a CMA could not give insulin to the residents. The facility's "Administering Medications" policy, revised April 2019, directed that medications were administered in a safe and timely manner, and as prescribed. The policy further directed only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so.	F0726					
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and observation,	F0609					

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F0609 SS = D	Continued from page 4 the facility failed to identify the lack of required staff, resulting in a fall for Resident (R) 2 as an allegation of neglect and report to the State Agency (SA) as required. Findings included: - R2's Electronic Medical Records (EMR) documented diagnoses of focal traumatic brain injury with loss of consciousness of 30 minutes or less, epilepsy (brain disorder characterized by repeated seizures), aphasia (condition with disordered or absent language function), need for assistance with personal care, dependence on wheelchair, lack of coordination, and muscle weakness. R2's "Quarterly Minimum Data Set" (MDS) dated 05/23/2026 documented a Brief Interview for Mental Status (BIMS) score of 00, which indicates severely impaired cognition. The MDS documented R2 was dependent on staff for eating, oral hygiene, toileting hygiene, shower/bathing self, upper and lower body dressing, putting on and taking off footwear, personal hygiene, transfers, and bed mobility. R2's "Activities of Daily Living Care Plan" revised on 02/20/2024 documented R2 was totally dependent on two staff members for repositioning and turning in bed. The plan of care documented R2 was totally dependent on two staff members for dressing. R2's "Fall Care Plan" interventions initiated on 07/31/2024 directed staff to ensure R2 was positioned in the center of the bed. R2's intervention initiated on 08/27/2024 directed that R2 had fall mats at the side of the bed to decrease injury if a fall occurred. The "Nurse's Note" dated 06/24/2026 at 05:56 AM documented R2 experienced a fall from bed during morning care. Certified Nurse Aide (CNA) M assisted R2 with getting dressed for the day when R1 rolled unexpectedly from the bed and fell to the floor. R2's bed was approximately waist high and upon impact, R2 hit the posterior aspect of his head. Upon assessment, a laceration to the back of R2's head was located and found to be bleeding. Consultant GG and Administrative Nurse D were notified and Consultant GG ordered R2 to be sent out to the			F0609			

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F0609 SS = D	Continued from page 5 emergency room for further evaluation. On 07/13/2026 at 03:19 PM, R2 had no fall mats around his bed or in his room. On 07/14/2026 at 12:40 PM, R2 sat in his wheelchair at the dining room table with CNA N assisting him with his meal. R2 appeared clean and well groomed. On 07/14/2026 at 11:27 AM, CNA O stated she would not provide cares for R2 as a one person assist. CNA O stated she had worked with him when he was on a different hallway, and she always performed his cares with another staff member. On 07/24/3036 at 01:07 PM, CNA M stated that she was alone when she was getting R2 dressed for the day. CNA M further stated that R2 had rolled, and it was unexpected. On 07/14/2026 at 01:50 PM, Administrative Nurse D stated had she missed that R2 needed two staff members to assist R2 in getting dressed. Administrative Nurse D further stated that the CNAs not being able to see the care plans explained a lot of the facility falls. Administrative Nurse D revealed that this was an allegation of neglect, and it should have been reported to the SA. The facility's "Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigation" policy, revised September 2022, documented all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property were reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy further documented all allegations were thoroughly investigated.			F0609			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as			F0689			

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F0689 SS = D	Continued from page 6 free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, and record review, the facility failed to ensure safe activities of daily living care while helping Resident (R) 2 get dressed for the day when there was only one staff member assisting R2 and R2 rolled off the bed and hit his head, resulting in a laceration, a hematoma, and being set out to the hospital for evaluation. Findings included: - R2's Electronic Medical Records (EMR) documented diagnoses of focal traumatic brain injury with loss of consciousness of 30 minutes or less, epilepsy (brain disorder characterized by repeated seizures), aphasia (condition with disordered or absent language function), need for assistance with personal care, dependence on wheelchair, lack of coordination, and muscle weakness. R2's "Activities of Daily Living Care Plan" revised on 02/20/2024 documented R2 was totally dependent on two staff members for repositioning and turning in bed. The plan of care documented R2 was totally dependent on two staff members for dressing. R2's "Quarterly Minimum Data Set" (MDS) dated 05/23/2026 documented a Brief Interview for Mental Status (BIMS) score of 00, which indicates severely impaired cognition. The MDS documented R2 was dependent on staff for eating, oral hygiene, toileting hygiene, shower/bathing self, upper and lower body dressing, putting on and taking off footwear, personal hygiene, transfers, and bed mobility. R2's "Fall Care Plan" interventions initiated on 07/31/2024 directed staff to ensure R2 was positioned in the center of the bed. R2's intervention initiated on 08/27/2024 directed that R2 had fall mats at the side of the bed to decrease injury if a fall occurred.			F0689			

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F0689 SS = D	Continued from page 7 R2's "Activities of Daily Living Care Plan" revised on 02/20/2024 documented R2 was totally dependent on two staff members for repositioning and turning in bed. The plan of care documented R2 was totally dependent on two staff members for dressing. The "Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form" dated 06/24/2026 at 05:27 AM documented R2 had a laceration to the back of his head. The "Interact Transfer Form" dated 06/24/2026 documented R2 the reason for transfer/discharge was a fall. The form documented R2 had a laceration to the back of his head. Review of the "Emergency Provider Report" dated 06/24/2026 documented R2 presented at the emergency department for evaluation after falling out of bed at his care facility. The facility staff reported that they were changing R2, when rolling R2 onto his side, staff said he rolled too far and fell onto the floor and sustained a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to the back of his head. A physical exam found a superoposterior scalp hematoma with minimal abrasion (scraping or rubbing away of skin) left of midline, tender to palpation, no depressions, or signs of a skull fracture. A computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) of R2's head without contrast and a cervical spine without contrast was ordered on 06/24/2026 at 05:40 AM. The impression of the brain was no evidence of acute intracranial abnormality. The impression of the cervical spine was no evidence of acute osseous abnormality involving the cervical spine. The "Nurse's Note" dated 06/24/2026 at 05:56 AM documented R2 experienced a fall from bed during morning care. The Certified Nurse Aide (CNA) M assisted R2 with getting dressed for the day when R1 rolled unexpectedly from the bed and fell to the floor. R2's bed was approximately waist high and upon impact R2 hit the posterior aspect of his head. Upon assessment, a laceration to the back of R2's head was located and found to be bleeding. Consultant GG and Administrative Nurse D were			F0689			

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F0689 SS = D	Continued from page 8 notified and Consultant GG ordered R2 to be sent out to the emergency room for further evaluation. On 07/13/2026 at 03:19 PM, R2 had no fall mats around his bed or in his room. On 07/14/2026 at 12:40 PM, R2 sat in his wheelchair at the dining room table with CNA N assisting him with his meal. R2 appeared clean and well groomed. On 07/14/2026 at 11:27 AM, CNA O stated she would not provide cares for R2 as a one person assist. CNA O stated she had worked with him when he was on a different hallway, and she always performed his cares with another staff member. On 07/14/2026 at 11:33 PM, CNA N stated that R2 only required one person while getting him dressed and then two people when getting him up into his wheelchair with the Hoyer (total body mechanical lift) lift. CNA N stated she would know what was needed for R2 in his chart or the nurses working would advise her. CNA N attempted to pull up R2's care plan and Kardex (nursing tool that gives a brief overview of the care needs of each resident) to verify R2's level of assistance required for his cares and could not see R2's care plan. R2's Kardex was located with no directions for the number of staff needed to provide R2 his activities of daily living. On 07/14/2026 at 01:07 PM, CNA M stated she was the one that was getting R2 up on the morning of 06/24/2026. CNA M stated she was getting him dressed by herself and the had rolled out of bed. CNA M stated she was not aware that he required two people to get him dressed for the day, or that he was supposed to have a fall mat by his bed. CNA M stated she had never seen one in R2's room. CNA M revealed that R2 did get a laceration from the fall and was bleeding. On 07/14/2026 at 11:41 AM, Licensed Nurse (LN) G pulled up R2's care plan and verified that R2 was to have fall mats beside his bed, and that he required assistance of two staff members with getting dressed. On 07/14/2026 at 11:44 AM, Administrative Nurse D stated R2's Kardex should have the cares that he	F0689			

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F0689 SS = D	Continued from page 9 needed in there to direct the CNAs. CNA N proceeded to open R2's Kardex for Administrative Nurse D and showed Administrative Nurse D only two interventions were listed in R2's Kardex, one being an intervention after the fall that occurred on 06/24/2026. Administrative Nurse D stated that the CNAs not being able to see the care plan is not new, they have never been able to see it, but they should be able to see the Kardex, and it should have interventions required to provide care for R2. Administrative Nurse D revealed she was not aware of the Kardex not having the information that the staff needed to know how to provide cares for the residents. On 07/14/2026 at 01:50 PM, Administrative Nurse D stated she missed that R2 needed two staff members to assist R2 in getting dressed. Administrative Nurse D further stated that the CNAs not being able to see the care plans explained a lot of the facility falls. The facility's "Activities of Daily Living (ADL), Support" policy, revised April 2025, documented residents were provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. The policy documented appropriate care, and services were provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). The facility's "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" policy, revised April 2021, documented an objective to establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems.			F0689			
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and observation, the facility failed to ensure Resident (R) 1 remained			F0760			

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F0760 SS = D	Continued from page 10 free from significant medication errors when staff administered fast acting insulin instead of the ordered long-acting insulin. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of shortness of breath, lack of coordination, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and type 1 diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R1's "Quarterly Minimum Data Set" (MDS) dated 03/19/2026 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated intact cognition. The MDS documented R1 received insulin injections seven days out of the last seven days. The MDS documented R1 had high risk drug class for hypoglycemic (less than normal amount of sugar in the blood), including insulin. R1's "Diabetes Mellitus Care Plan" revised on 09/19/2023 directed staff to monitor for signs and symptoms of hyperglycemia (increased blood sugar, increased thirst, increased urination, and polyphagia (feeling of extreme, insatiable hunger). The plan of care directed staff to administer medications per the medical directors' order and monitor blood glucose finger stick per the medical directors' orders. R1's "Orders" tab documented the following physician orders for insulin: Glucagon (raises blood sugar and is used in diabetes to treat hypoglycemia) kit one milligram (mg), inject one mg intramuscularly (IM) and phone every 24 hours as needed for blood sugar below 50 mmol/L give one mg IM and notify the medical director related to DM without complications, ordered on 01/25/2022. Novolog (a rapid-acting insulin used to control blood sugar in adults and children with DM, typically taken five to ten minutes before meals) Flex Pen solution pen-injector 100 units/ML (insulin Aspart) inject 20 U's subcutaneously three times a day related to Type 1 DM without complications, hold for blood sugar less than 70 or unable to eat. Notify the			F0760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175180		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/14/2026	
NAME OF PROVIDER OR SUPPLIER OVERLAND PARK POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5211 W 103RD STREET , OVERLAND PARK, Kansas, 66207			
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F0760 SS = D	Continued from page 11 medical director if blood sugar is less than 70 mmol/L or more than 400 mmol/L, ordered on 03/22/2023 Basaglar (a long-acting insulin used to manage blood sugar in type 1 and type 2 diabetes mellitus, providing a steady insulin level for up to 24 hours) Kwik Pen solution pen-injector 100 units/ML (insulin Glargine) inject 65 U's subcutaneously (beneath the skin) at bedtime related to Type 1 DM without complications, hold for blood sugar less than 70 mmol/L or unable to eat. Notify the medical director if blood sugar is less than 70 mmol/L or more than 400 mmol/L, ordered on 04/07/2026. Glucagon subcutaneous solution 1 mg/0.2 milliliter (mL) inject one mg/mL subcutaneously one time only for hypoglycemia for one day, ordered on 06/11/2026 The "Nurse's Note" dated 06/11/2026 at 10:33 PM documented the Certified Medication Aide (CMA) gave the wrong medication for R1. The scheduled medication was glargine insulin 65 U, but the CMA administered Novolog 45 U, per CMA report. R1 was assessed and found to be alert and oriented at that time. The note further documented the event was reported to Consultant GG and Administrative Nurse D. R1 reportedly had a blood sugar of 241 mmol/L at the time of the incident, and R1's blood sugar was checked every ten minutes as ordered by Consultant GG. R1's blood sugar at 10:32 PM was 132 mmol/L. The "Electronic Medication Administration Note" dated 06/11/2026 at 11:03 PM documented R1 received the wrong medication. The "Nurse's Note" dated 06/11/2026 at 11:44 PM documented glucagon one milligram subcutaneous was administered STAT (immediately) at 11:03 PM and R1's blood sugar went up from 104 mmol/L to 155 mmol/L after 30 minutes from administration. The "Nurse's Note" dated 06/12/2026 at 01:49 AM documented R1's blood sugar dropped down to 55 mmol/L. Consultant GG was called, and a voice message was left, and Administrative Nurse D was called to be informed. R1's level of cognition was still intact. R1 was given oral glucose gel, and a glass of milk.	F0760					

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F0760 SS = D	Continued from page 12 The "Nurse's Note" dated 06/12/2026 at 07:43 AM documented R1's blood sugar improved, her level of consciousness was intact, and at 06:00 AM her blood sugar was 140 00o/L. Review of the "Medication Error report # 648" completed on 06/11/2026 at 09:35 PM by Licensed Nurse (LN) G documented R1 received the wrong medication from CMA R. R1 was scheduled to received glargine used to manage blood sugar in type 1 and type 2 diabetes mellitus 65 units but CMA R administered Novolog 45 U as CMA R reported. The immediate actions taken for R1 included assessing R1 who was documented to be alert and oriented at that time. The event was reported to Consultant GG and Administrative Nurse D. On 06/11/2026 at approximately 08:00 PM, Certified Medication Aide (CMA) R's written statement documented CMA R took R1's blood sugar and proceeded to dial up her insulin. CMA R simply misread the order on the screen and grabbed the wrong insulin pen. CMA R documented the dose for 65 U and that is what CMA R dialed up in the pen. CMA R then injected R1 with the pen. CMA R documented that R1 did not get the entire amount, due to CMA R stopping the injection after realizing it was the wrong insulin pen. CMA R documented approximately more than half of the 65 U's were injected. CMA R dialed the remainder back into the pen and alerted the nurse. On 07/14/2026 at 12:52 PM, CMA R stated that she had given R1 the insulin, and while she was administering R1's insulin, she realized it was the wrong medication, and she stopped injecting it into R1 and removed it. CMA R stated R1 did not get the entire dose of insulin that she had dialed up. CMA R revealed she immediately informed the nurse about the medication error because she did not want anything bad to happen to R1. On 07/13/2026 at 02:18 PM, LN H stated a CMA could not administer insulin to a resident; only a nurse could do that, but if a resident had an order to self-administer, LN H thought a CMA could dial up the insulin and hand it to a resident for the resident to administer it themselves.	F0760					

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F0760 SS = D	Continued from page 13 On 07/14/2026 at 11:20 AM, LN G was unable to be reached via phone. On 07/14/2026 at 11:50 AM, LN I stated that a CMA could not administer insulins in the state of Kansas. LN I further stated it had been that way as long as she could remember. On 07/13/2026 at 02:05 PM, Administrative Nurse D stated that when she found out about the medication error, she interviewed CMA R and let her know that this was not Missouri, and she could not administer insulin in this state. Administrative Nurse D further revealed that CMA R then informed Administrative Nurse D that she had given insulin in the facility in the past. On 07/14/2026 at 01:50 PM, Administrative Nurse D stated that LN G was an employee of the facility and that she educated LN G that a CMA could not give insulin to the residents. Administrative Nurse D stated only LN G had documented training on not allowing a CMA to give insulins. Administrative Nurse D revealed that she has had conversations with different nurses on the floor, but did not have anything documented showing those conversations or education. The facility's "Administering Medications" policy, revised April 2019, directed that medications were administered in a safe and timely manner, and as prescribed. The policy further directed only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The facility's "Adverse Consequences and Medication Errors" policy, revised June 2025, documented a medication error was defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders. A significant medication-related error is defined as requiring treatment with a prescription medication.			F0760			