

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/03/2026
NAME OF PROVIDER OR SUPPLIER TRUSTWELL LIVING OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10665 BARKLEY OVERLAND PARK, KS 66212		
(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 represents the findings of a resurvey with attached intakes 199241, 199237, 199072, 199024, 198681, 198331, 198030, 197854, and 192328 at the above-named assisted living facility conducted 07/29/26-08/03/26.	S 000		
S 115 SS=F	26-39-103 (d) Resident Right Inspection of Records (d) Inspection of records. (1) The administrator or operator shall ensure that each resident or resident's legal representative is afforded the right to inspect records pertaining to the resident. The administrator or operator, or the designee, shall provide a photocopy of the resident's record or requested sections of the resident's record to each resident or resident's legal representative within two working days of the request. If a fee is charged for the copy, the fee shall be reasonable and not exceed actual cost, including staff time. (2) The administrator or operator shall ensure access to each resident ' s records for inspection and photocopying by any representative of the department. This STANDARD is not met as evidenced by: KAR 26-39-103 (d) (2) The facility reported a census of 53 residents with three residents included in the sample and two closed chart reviews. Based on interview and record review, the facility failed to ensure access to each resident's complete record for inspection by any representative of the department. Findings included:	S 115		

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

TITLE

(X6) DATE

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S 115	Continued From page 1 - Record review for R1 revealed an admission date of 10/15/24 with diagnoses of dementia and unsteady gait. Review of R1's electronic record revealed a representative of the department was denied access to review areas including diagnoses list, functional capacity screenings, and advanced directives. - Record review for R2 revealed an admission date of 03/25/24 with diagnoses of epilepsy, dementia, and anorexia. Review of R2's electronic record revealed a representative of the department was denied access to review areas including diagnoses list, functional capacity screenings, and advanced directives. - Record review for R3 revealed an admission date of 10/23/24 with diagnoses of dementia and unsteady gait. Review of R3's electronic record revealed a representative of the department was denied access to review areas including diagnoses list, functional capacity screenings, and advanced directives. On 07/29/26 at 01:30 PM Administrative Staff A was notified the electronic medical record access given to the department did not allow access to multiple items including diagnoses list, functional capacity screenings, and advanced directives. Email received 07/30/26 at 02:00 PM from Administrative Staff A revealed she was notified the electronic medical record access provided to	S 115		

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S 115	Continued From page 2 the department was the correct access and any other information would be given if requested. The facility failed to ensure access to each resident's complete record for inspection by any representative of the department.	S 115		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 53 residents with three residents included in the sample and two closed record reviews. Based on observation, interview, and record review the facility failed to ensure designated facility staff documented the residents' functional capacity accurately on the functional capacity screening form for Resident (R) 1 and R3. Findings included: - Record review for R1 revealed an admission date of 10/15/24 with diagnoses of dementia and unsteady gait. The 07/08/26 "Functional Capacity Screen" (FCS) was for a significant change and identified R1 required physical assistance with bathing, dressing, toileting, transfers, and mobility; was	S3082		

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S3082	Continued From page 3 unable to perform management of medications and treatments; had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties; had impaired vision, hearing, and decision-making; and was at risk of falls. The FCS failed to indicate R1's problem of wandering. The 05/08/26 (most recent) "Negotiated Service Agreement" NSA identified R1 was independent with transfers and required escort off the memory care unit. The NSA indicated R1 had a wanderguard device due to his wandering risk and failed to indicate any services provided for impaired vision, hearing, or decision-making. On 08/03/26 at 01:13 PM R1 propelled self down hallway away from his apartment. When asked, R1 was unable to state reason for going away from room or what his purpose was for traveling in the wrong direction. On 08/03/26 at 01:28 PM Activity Staff G gave R1 an apron and instructed him to the activity starting. R1 turned and propelled self down hallway. R1 pointed down hall and was unable to state why he was leaving activity area. On 08/03/26 at 03:45 PM Administrative Staff A confirmed R1's FCS failed to identify his risk of wandering. - Record review for R3 revealed an admission date of 10/23/24 with diagnoses of dementia and unsteady gait. The 07/08/26 FCS identified R3 required physical assistance with bathing, dressing, toileting, and management of medications; required supervision with transferring, eating, and mobility;	S3082		

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S3082	Continued From page 4 was incontinent of bladder; had short-term memory, long-term memory, memory recall, and decision-making difficulties; had impaired vision and decision-making; and usually understood and usually understandable during communication. The FCS failed to document R3's risk for falls. The 07/08/26 NSA identified staff made sure R3 had his glasses on, he was checked and changed, and had a clutter free environment to prevent falls. The 06/16/26 "General" note documented R3 was found on floor and did not remember how it happened. On 08/03/26 at 03:45 PM Administrative Staff A confirmed R3's FCS failed to identify his problem of falls. The facility failed to ensure designated facility staff documented the residents' functional capacity accurately on the FCS for R1 and R3.	S3082		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident 's legal representative, facility staff, the case	S3092		

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S3092	Continued From page 5 manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d) (2) The facility reported a census of 53 residents with three residents included in the sample and two closed record reviews. Based on interview and record review the facility failed to ensure facility staff reviewed and revised the Negotiated Service Agreement (NSA) for Resident (R) 1 and R2 upon significant change in condition as defined in K.A.R. 26-39-100. Findings included: - Record review for R1 revealed an admission date of 10/15/24 with diagnoses of dementia and unsteady gait. The 07/08/26 "Functional Capacity Screen" (FCS) was for a significant change and identified R1 required physical assistance with bathing, dressing, toileting, transfers, and mobility; was unable to perform management of medications and treatments; had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties; had impaired vision, hearing, and decision-making; and was at risk of falls. The 05/08/26 (most recent) NSA identified R1 was independent with transfers and required escort off the memory care unit. The NSA failed to indicate any services provided for impaired vision, hearing, or decision-making.	S3092		

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S3092	Continued From page 6 Interview of Certified Nurse Aide D on 08/03/26 at 01:13 PM revealed R2 required assistance from staff for transfers and mobility since he had a fall with injury a few weeks ago. On 08/03/26 at 03:15 PM Administrative Staff A confirmed R1's record failed to include an updated NSA upon change in condition. - Record review for R2 revealed an admission date of 03/25/24 with diagnoses of epilepsy, dementia, and anorexia. The 07/16/26 (most recent) FCS was for a significant change and identified R2 was unable to perform bathing, dressing, toileting, transfers, mobility, and management of medications and treatments; was incontinent of bladder; had no cognitive difficulties; and had impaired vision, hearing, and decision-making. The 04/06/26 (most recent) NSA indicated facility staff assisted R2 with bathing, dressing, toileting, transfers, mobility, and management of medications and treatments. R2's record failed to include an updated NSA on 07/16/26 when she had an FCS completed for significant change. On 08/03/26 at 03:15 PM Administrative Staff A confirmed R2's record failed to include an updated NSA when she had a significant change. The facility failed to ensure facility staff reviewed and revised the NSA for R1 and R2 upon change in condition.	S3092			

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S3101	Continued From page 7	S3101		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (h) The facility reported a census of 53 residents with three residents included in the sample and two closed record reviews. Based on interview and record review the facility failed to ensure that each individual involved in the development of the Negotiated Service Agreement (NSA) signed the agreements for Resident (R) 1 and R3. Findings included: - Record review for R1 revealed an admission date of 10/15/24 with diagnoses of dementia and unsteady gait. The 07/08/26 Functional Capacity Screen (FCS) was for a significant change and identified R1 required physical assistance with bathing, dressing, toileting, transfers, and mobility; was unable to perform management of medications and treatments; had short-term memory, long-term memory, memory recall, and decision-making cognitive difficulties; had impaired vision, hearing, and decision-making; and was at risk of falls. The FCS failed to indicate R1's problem of wandering.	S3101		

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S3101	Continued From page 8 The 05/08/26 (most recent) NSA identified R1 was independent with transfers and required escort off the memory care unit. The NSA indicated R1 had a wanderguard device due to his wandering risk and failed to indicate any services provided for impaired vision, hearing, or decision-making. The NSA failed to be signed by each individual involved in the development. - Record review for R3 revealed an admission date of 10/23/24 with diagnoses of dementia and unsteady gait. The 07/08/26 FCS identified R3 required physical assistance with bathing, dressing, toileting, and management of medications; required supervision with transferring, eating, and mobility; was incontinent of bladder; had short-term memory, long-term memory, memory recall, and decision-making difficulties; had impaired vision and decision-making; and usually understood and usually understandable during communication. The FCS failed to document R3's risk for falls. The 07/08/26 NSA identified staff assisted with all activities of daily living, made sure R3 had his glasses on, he was checked and changed, and had a clutter free environment to prevent falls. The NSA failed to be signed by each individual involved in the development. On 08/03/26 at 03:15 PM Administrative Staff A confirmed R1 and R3's NSAs lacked signatures on the last page including all those involved in the development of the agreements. The facility failed to ensure that each individual involved in the development of the NSA signed the agreements for R1 and R3.	S3101		

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S3211 SS=F	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g) (3) The facility reported a census of 53 residents. Based on observation and interview, the facility failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of 17 over-the-counter (OTC) medications in the medication carts and medication room. Findings included: - Observation on 07/29/26 at 10:16 AM revealed the memory care medication cart contained the following OTC medications not labeled with residents' full names: One bottle cetirizine (antihistamine) 10 milligram (mg), 90 tablets	S3211		

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S3211	Continued From page 10 One bottle vitamin 3 (supplement) 180 mg, 500 softgels One bottle acetaminophen (analgesic) 500 mg, 400 gelcaps One bottle lutein 25 mg & zeaxanthin (supplement) 5 mg, 140 softgels One bottle aspirin (anti-inflammatory) 81 mg, 365 tablets One bottle vitamin B12 (supplement) 3000 microgram, 220 gummies One bottle fish oil (supplement) 1000 mg, 400 softgels On 07/29/26 at approximately 10:35 AM Administrative Staff A confirmed the OTC medications should be and were not labeled with residents' full names. - Observation on 07/29/26 at 10:56 AM revealed the afternoon assisted living medication cart contained the following OTC medications not labeled with residents' full names: One bottle acetaminophen (analgesic) 500 mg, 325 caplets One bottle diphenhydramine (antihistamine) 25 mg, 600 tablets One bottle preserision AREDS 2 (supplement) 120 softgels One bottle polyethelyene glycol 3350 (laxative) powder, 29.9 ounces The morning medication cart contained the following OTC medications not labeled with residents' full names: Two bottles glucosamine chondroitin (supplement) 100 tablets Two bottles aspirin (anti-inflammatory) 81 mg, 120 tablets	S3211		

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S3211	Continued From page 11 One bottle vitamin D3 (supplement), 100 tablets One bottle sodium carboxymethylcellulose (ocular lubricant) 0.25%, 0.5 fluid ounces On 07/29/26 at approximately 11:25 PM Certified Medication Aide C confirmed the OTC medications were not labeled with resident's full names. The facility failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of 17 OTC medications.	S3211			
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.	S3215			

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S3215	Continued From page 12 (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) The facility reported a census of 53 residents. Based on observation and interview, the facility failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations. Findings included: - Observation on 07/29/26 at 10:16 AM of the memory care medication cart revealed the following medications: One bottle calcium carbonate (antacid) 500 milligram (mg), 150 chewable tablets with expiration date 07/22/26 per pharmacy, One box naloxone (opioid antagonist) 2 mg/2 milliliter (ml), one syringe use by date 03/31/26 per pharmacy, One tube sodium fluoride (supplement) 1.1% dental cream, 51 grams with use by 03/1/26 per pharmacy, One tube biofreeze (counter-irritant) 4% gel, 3 fluid ounces use by 05/24/26 per pharmacy,	S3215		

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S3215	Continued From page 13 One vial in box of fluphenazine decanoate (antipsychotic) 125 mg/5 ml, 5 ml vial with exp 02/2026 per manufacturer On 07/29/26 at approximately 10:25 AM Licensed Nurse E confirmed the medications were past date of use. - Observation on 07/29/26 at 10:56 AM of the memory care medication cart revealed the following medications: One tube diclofenac sodium topical gel 1%, 100 grams use by 6/7/26 per pharmacy, One container chewable multivitamin, 250 tablets with use by 7/15/26 per pharmacy On 07/29/26 at approximately 11:10 AM Administrative Staff A confirmed the medications were past date of use. The facility failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations.	S3215			
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to	S3298			

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S3298	Continued From page 14 prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (d) The facility reported a census of 53 residents. The facility had a main kitchen where food was stored, prepared, and served. Based on interview and record review the facility failed to ensure food was served at the proper temperatures. Findings included: - Review of the food temperature logs for 02/01/26 through 07/28/26 revealed food temperatures were not recorded for 66 out of 177 breakfast meals, 101 out of 177 lunch meals, and 145 out of 177 dinner meals. On 07/29/26 at approximately 01:30 PM Administrative Staff A confirmed the food temperature logs were not completed for each meal. Dietary guidelines for Americans 2005 recommended using a clean thermometer that measured the internal temperature of cooked food to make sure food is cooked to and held at proper temperatures and to keep food out of the "danger zone" (40 degrees Fahrenheit to 140 degrees Fahrenheit) where bacteria can multiply	S3298		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/03/2026
NAME OF PROVIDER OR SUPPLIER TRUSTWELL LIVING OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10665 BARKLEY OVERLAND PARK, KS 66212		
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S3298	Continued From page 15 rapidly. The facility failed to ensure food was served at the proper temperatures.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 53 residents. The facility had a main kitchen where food was stored and prepared for all residents. Based on observation and interview the facility failed to ensure food items were stored under safe conditions. Findings included: - Observation on 07/29/26 at 09:29 AM in the kitchen revealed a pantry with the following food items: Nineteen cans of cranberry sauce with best by date of 02/25/26, One opened and unsealed 12-ounce bag of chocolate chips, One opened and unsealed bag of cereal flakes	S3299		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/03/2026
NAME OF PROVIDER OR SUPPLIER TRUSTWELL LIVING OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 10665 BARKLEY OVERLAND PARK, KS 66212		
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S3299	Continued From page 16 On 07/29/26 at approximately 09:37 AM Dietary Staff F confirmed the foods were not sealed properly or were past date of use. - Observation on 07/29/26 at 09:42 AM of the walk-in refrigerator contained the following food items that lacked labels identifying what they were and a date the food was opened. Two saran wrapped blocks of sliced yellow cheese, Two saran wrapped blocks of sliced white cheese On 07/29/26 at approximately 09:44 AM Dietary Staff F confirmed the foods were not labeled properly and he expected them to be dated. The facility failed to ensure foods were stored under safe conditions.	S3299			