

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF OVERLAND PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 10101 W 127TH ST OVERLAND PARK, KS 66213		
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S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaints 199492, 199416, 199217, 198874, 198711, 198630, 198518, 198248, 197491, 197378, 197309, 197243, 197221, 197027, 196947, 196860, 196262, and 193695 at the above named assisted living conducted on 09/10/26, 09/14/26, 09/15/26, 09/16/26, 09/17/26, and 09/21/26. The facility reported a census of 53 residents. 16 residents were included in the sample.	S 000		
S3026 SS=D	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: K.A.R 26-41-101 (f)(1)(B) Based on observation, interview, and record review, the facility failed to protect Resident (R) 12 from neglect when facility staff shut off the northwest door alarm without looking to verify if a resident had not exited the building when the alarm sounded. On 09/13/25 at approximately 06:08 PM, R12 exited the building without staff knowledge, ambulated approximately 136 feet. Staff found R12 at 06:20 PM, on the ground,	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 under a tree after a fall. R12 had not been seen by staff for approximately 15 minutes. Findings included: - R12 admitted on 01/23/25 with a diagnosis of Alzheimer's disease and required supervision. The 09/09/25, Functional Capacity Screen revealed R12 was independent with transfers and walking/mobility. She had short-term and long-term memory, memory/recall, and decision-making/ cognitive difficulties, a risk for falls and wandering. The 09/09/2, Negotiated Service Agreement revealed R12 ambulated independently without a device and received staff assistance with expressing needs and verbal cues as needed due to memory impairment. The facilities undated investigation dated 09/13/25 revealed staff reviewed the camera footage from facility. At approximately 05:37 PM, R12 exited the common area into the hallway and Certified Nurses Aide (CNA) N redirected R12 to sit in a chair in the commons area. At approximately 05:57 PM, R12 exited the common area again and entered a resident room. R12 immediately exited and walked to an exit door and began pulling on it, which caused the alarm to sound. Certified Medication Aide (CMA) E redirected R12 away from the door and entered the door code to turn off the alarm. At approximately 06:05 PM, R12 walked to the exit door and pulled on the door until it released. R12 can be seen entering the back hallway. At 06:05 PM, CMA E walked to the exit door, looked down both hallways, entered the code to clear the door alarm and returned to the medication cart. At	S3026			

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S3026	Continued From page 2 06:08 PM, R12 exited the unalarmed exit door to the outside area. At approximately 06:08 PM, CNA G can be heard asking CMA E where R12 was and began searching room to room and then exited the building at 06:18 PM. The 09/13/25 notarized Witness Statement" by CNA G reported after assisting another resident he noticed R12 was not in his line of vision. He asked CMA E if she had seen R12 and she responded she wasn't sure. CNA G searched other resident rooms. At 06:20 PM CNA G looked out a window and saw R12 lying on the ground under a tree. CNA G ran out of the building to assist her. Observation on 09/16/26 at approximately 11:46 AM revealed the alarmed northwest door would not open unless pulled on for 15 seconds and then the alarm would sound. The alarm door opened into a hallway which had an unalarmed door that led to the outside the exit door opened to a sidewalk and a grass area. The facility was lined with tree's next to the windows of the facility. The tree R12 was found under was approximately 136 feet from the exit door. The facility's undated "Missing Resident Policy" under 1 and 2 documented if an exit door is alarming staff should: 1. Immediately go to the alarming door to ensure that a resident has not eloped. 2. If staff does not see resident; they will continue out the door and walk each direction to ensure the resident is not outside.	S3026		
S3102 SS=D	26-41-202 (i) Negotiated Service Agreement Service Received	S3102		

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S3102	Continued From page 3 (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident 's negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR 26-41-202(i) Based on interview and record review the facility failed to ensure Resident (R) 6 received visual checks every two to three hours to ensure he was in bed and breathing and that his bed alarm functioned appropriately as described in his "Negotiated Service Agreement" (NSA). During the night of 05/20/26 to 05/21/26 R6's bed alarm did not activate when he fell from his bed. R6 was last seen by facility staff at approximately 11:20 PM during a visual rounding check. He was next seen dead, face down on the floor at approximately 05:20 the next morning during a rounding check which was six hours since he was last seen. Findings included: - Record review for R6 revealed an admission date of 08/19/25 with diagnoses of dementia and insomnia. The 08/19/25 admission "Functional Capacity Screen" (FCS) identified R6 required supervision with transfers and physical assistance with walking/mobility. He had short-term memory, memory recall, and decision-making cognitive difficulties and was at risk for falls. The 02/26/26 "NSA" identified R6 received assistance from one staff for transfers and walking/mobility. He received cues and prompts	S3102		

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S3102	Continued From page 4 from facility staff for cognitive difficulties. The "NSA" documented the following: In the "Safety/Call System" section: Safety precautions and close surveillance would be maintained by staff. R6 was unable to understand and how to pull the call cord intentionally to ask for help. Staff would make frequent checks throughout each shift and "in particular when he was alone" in his apartment. In the "Fall Risk" section: R6 had a history of falling and required staff involvement to ensure his safety. He had a pressure alarm on his bed and chair to alert staff when he began to move or attempt to stand up without help. Facility staff responded promptly when the alarm activated. Staff ensured the alarm was turned on and functioning when R6 was in bed. Staff reported any concerns with the pressure alarm to a licensed nurse or Administrative Staff A. In the "How to Assist with Transfers" section: R6's falls occur at bedtime when he got out of bed and attempted to walk. In the "How to Assist at Bedtime" section: R6 often got up in the middle of the night and attempted to walk and get dressed. Bed alarm was in place to alert staff when R6 attempted to get out of bed. R6 used oxygen with a nasal cannula at all times during the night which he often removed. Staff performed frequent checks to place oxygen back on. Staff checked R6 every two to three hours through the night to ensure he was in bed and breathing. The 05/21/26 at 05:47 AM late entry "Incident Note" progress note documented the nurse received a call from Certified Medication Aide	S3102		

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S3102	Continued From page 5 (CMA) D reporting he found R6 laying face down in his apartment, bleeding from his nose and a laceration on his forehead, was not breathing and had no pulse. The 05/28/26 facility's "Investigation Report" documented CMA reported R6's bed alarm never activated during the night. Sometimes R6 unplugged the bed alarm. The 05/27/28 notarized "Witness Statement" by CMA D reported he worked the night shift with Certified Nurse Aide (CNA) H. During rounds at 05:20 AM he found R6 laying face down on the floor of his room bleeding from his nose and forehead and was unresponsive. He provided rounds to the residents three times during the night. At 11:20 PM R6 slept deeply, snored, and woke up while CMA D checked his oxygen level. During rounds between 01:00 and 02:00 AM, CMA D heard snoring coming from R6's room but did not enter the room to visually check R6. At 05:20 AM CMA D found R6 on the floor with the bed alarm plugged in and not sounding. The undated and unsigned "Witness Statement" by CNA H reported while she assisted other residents, CMA D informed her R6 had died on the floor of his apartment. She assisted CMA D to clean R6 and change his clothes. The "Witness Statement" did not address if CNA provided rounding checks through the night or heard R6's bed alarm activate. On 09/14/26 at 09:55 AM Administrative Staff A stated she was unaware who assisted R6 to bed the night before he died but he normally stayed up late. R6 often turned his bed alarm off. The revised 05/14/25 facility's "Rounding Policy"	S3102		

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S3102	Continued From page 6 documented all residents would be viewed during rounding checks to ensure they were breathing and safe at least every two hours or more or less often as indicated in the "NSA." The facility's undated "Coordination/Individualization of Services" policy documented all services would be tailored to each individual's specific needs with cares provided by staff based on the "NSA." The facility failed to ensure R6 received visual checks every two to three hours to ensure he was in bed and breathing and that his bed alarm functioned appropriately as described in his "NSA."	S3102		
S3171 SS=D	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) Based on interview and record review, the facility failed to provide healthcare services for R9 in accordance with professional standards of practice when an unidentified Certified Medication Aide (CMA) took a telephone order for hydromorphone 1 milligram/ milliliter take 0.25 milliliter sublingually every hour as needed for shortness of breath or pain.	S3171		

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S3171	Continued From page 7 Findings included: R9 diagnoses included Alzheimer's disease. The 10/15/25 Functional Capacity Screen revealed R9 was unable to perform management of medications. The 11/15/25 Negotiated Service Agreement (NSA) revealed facility staff were to administer medications R9 admitted on 10/15/25. The NSA dated 11/25/25 directed facility staff to prepare and administer R9's medications. Review of facility report revealed a typed in note that CMA E handed Administrative Nurse B a telephone order from the unidentified CMA who worked the previous shift. Review of Kansas Certified Medication Aide Curriculum under section titled "Legal Responsibilities" revealed the follow under a subsection titled "It is not legal for a medication aide: 1)To give medication by any route that involves puncturing the skin, such as intramuscular or subcutaneous injections or through intravenous lines. 2)To take phone order from a physician, physician's assistant, advance practice registered nurse (APRN), dentist, pharmacist." On 9/21/26 at approximately 02:08 PM, Administrative staff A confirmed an unidentified CMA took a telephone order. Administrative Staff A continued to confirm CMA's were not allowed to	S3171		

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S3171	Continued From page 8 take a telephone order. The failure placed R9 at risk for a medication error.	S3171			
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) Based on interview and record review the facility failed to administer medications to Resident (R) 9 and R14 in accordance with their medical care provider's orders. Findings included:	S3200			

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S3200	Continued From page 9 - Record review for R9 revealed an admission date of 11/25/25 with a diagnosis of Alzheimer's disease. The 10/15/25 "Functional Capacity Screen" (FCS) identified R9 required was unable to perform management of medications. The 11/15/25 "Negotiated Service Agreement" (NSA) identified facility staff managed R9's medications. The 10/28/25 "Verbal Order" documented 1 milligram (mg)/1 milliliter (mL) hydromorphone (an opioid pain-relieving medication) oral liquid; administer 0.25 mL sublingually every hour as needed for shortness of breath. The 10/28/25 at 03:06 PM late entry "Progress Note" documented Certified Medication Aide (CMA) E administered two mL of hydromorphone twice that day instead of 0.25 mL as ordered. - Record review for R14 revealed an admission date of 11/09/20 with a diagnosis of dementia. The 05/18/26 "FCS" identified R14 was unable to perform management of medications. The undated "NSA" identified facility staff managed R14's medications. The 10/07/24 physician's order documented tramadol (an opioid pain-relieving medication) 50 mg one tablet every eight hours for pain. The 08/07/25 at 12:18 PM late entry "Progress Note" documented R14 received a double dose of tramadol 50 mg.	S3200		

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S3200	Continued From page 10 On 09/17/26 at approximately 02:21 PM Administrative Staff A confirmed R9 and R14 received extra medication that was not according to physician's orders. The 03/11/25 facility's "Medication Administration" policy documented all medications would be administered by a licensed nurse or CMA in accordance with prescribed orders, facility policy, and all Federal and State laws and regulations. The facility failed to administer medications to R9 and R14 in accordance with their medical care provider's orders.	S3200		
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.	S3320		

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S3320	Continued From page 11 FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) Based on observation and interview the facility failed to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 09/10/26 at approximately 09:45 AM in House C's kitchen revealed a cabinet with a lock installed that was unlocked. The cabinet contained a gallon container of blue colored heavy duty de-limer liquid with a label that read "Warning! Causes serious eye irritation. Wear eye or face protection. . . Do not ingest." - On 09/10/26 at approximately 09:45 AM Administrative Nurse B confirmed the gallon container of de-limer was stored in an unlocked area. - Observation on 09/10/26 at approximately 11:04 AM in House A's kitchen revealed a cabinet with a lock installed that was unlocked. The cabinet contained a gallon container of blue colored dishwasher machine rinse aid liquid with a label that read "Keep out of reach of children." - On 09/10/26 at approximately 11:04 AM Administrative Nurse B confirmed the gallon container of dishwasher machine rinse aid was stored in an unlocked area. The undated facility's "Chemical Storage and	S3320			

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S3320	Continued From page 12 Safety Policy" documented all chemicals and hazardous substances would be stored in a manner to protect residents, staff, and visitors from accidental exposure, misuse, or injury. All chemicals would be kept in designated areas that were inaccessible to residents and unauthorized individuals. The facility failed to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		