

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046095	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/30/2026
NAME OF PROVIDER OR SUPPLIER HOMESTEAD ESTATES OF OVERLAND PARK MEMOI		STREET ADDRESS, CITY, STATE, ZIP CODE 12701 PFLUMM ROAD OVERLAND PARK, KS 66213		
(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 complaints 199872, 199694, 199637, 199547, 199426, 199351, 199253, 196977, 196839, and 19921 at the above named assisted living conducted on 09/28/26, 09/29/26, and 09/30/26. The facility reported a census of 48 residents. The sample included 10 residents.	S 000		
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) Based on interview and record review the facility failed to ensure each individual involved in the development of the "Negotiated Service Agreement" (NSA) signed the agreement for Resident (R) 1, R3 and R6. Findings included: - Record review for R1 revealed an admission date of 06/14/23 with diagnoses of dementia, restlessness, and irritability and anger. The 08/06/26 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with	S3101		

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

TITLE

(X6) DATE

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S3101	Continued From page 1 bathing and management of medications and treatments. He had short-term memory, memory/recall, and decision-making cognitive difficulties and was at risk for falls, impaired decision-making, wandering, and inappropriate behavior. The 08/06/26 "NSA" identified R1 received assistance from facility staff for bathing and a nurse delegated management of medications and treatments according to a physician's orders. Facility staff broke tasks into smaller tasks to support R1's short-term memory and kept his routine constant as much as possible for cognitive difficulties. Staff became familiar with R1's routine, anticipated his needs, and maintained a safe environment to prevent injury from falls. R1 had a durable power of attorney (DPOA) for impaired decision-making. R1 resided in a secured memory care with locked entry and exit doors to keep him safe from wandering. Staff reported R1 experienced escalated agitation or un-directable behaviors immediately to the nurse for inappropriate behaviors. The 08/06/26 "NSA" lacked a signature by R1's legal representative. - Record review for R3 revealed an admission date of 04/06/26 with a diagnosis of Alzheimer's disease. The 05/04/26 "FCS" identified R3 required physical assistance with toileting and management of medications and treatments. She was frequently incontinent of bladder and had memory/recall and decision-making cognitive difficulties. R3 was at risk for falls, impaired decision-making, and wandering.	S3101		

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S3101	Continued From page 2 The 05/04/26 "NSA" identified R3 received assistance from facility staff for toileting according to a schedule and a nurse delegated management of medications and treatments according to a physician's orders. Facility staff monitored incontinence supplies and restocked when needed. Facility staff broke tasks into smaller tasks to support R3's short-term memory and kept her routine constant as much as possible for cognitive difficulties. Staff became familiar with R3's routine, anticipated her needs, and maintained a safe environment to prevent injury from falls. R3 had a DPOA for impaired decision-making. R3 resided in a secured memory care with locked entry and exit doors and staff promoted purposeful wandering to keep her safe. The 05/04/26 "NSA" lacked a signature by R3's legal representative. - Record review for R6 revealed an admission date of 07/01/25 with diagnoses of neurocognitive disorder with Lewy bodies and schizoaffective disorder. The 04/15/26 "FCS" identified R6 required physical assistance with management of medications and was unable to perform management of treatments. He had long-term memory, memory/recall and decision-making cognitive difficulties and was at risk for impaired decision-making and wandering. The 04/15/26 "NSA" identified R6 received nurse delegation according to a physician's orders for management of medications and treatments. Facility staff broke tasks into smaller tasks to support R6's short-term memory and kept his routine constant as much as possible for	S3101		

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S3101	Continued From page 3 cognitive difficulties. R6 had a DPOA for impaired decision-making. R6 resided in a secured memory care with locked entry and exit doors and staff promoted purposeful wandering to keep him safe. The 04/15/26 "NSA" lacked a signature by R6's legal representative. On 09/30/26 at approximately 02:27 PM Administrative Nurse C confirmed R1, R3, and R6's "NSAs" lacked signatures of all individuals involved in the development of the "NSAs." On 09/30/26 at 02:55 PM an "NSA" policy was requested which the facility did not provide. The facility failed to ensure each individual involved in the development of the "NSA" signed the agreement for R1, R3, and R6.	S3101		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) Based on interview and record review the facility failed to ensure licensed staff documented all incidents, symptoms, indications of illness or	S3261		

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S3261	Continued From page 4 injury including the dates, times, actions taken, and results of the actions for Residents (R)5, R8, and R9. Findings included: - Record review for R5 revealed an admission date of 06/17/26 with diagnoses of dementia and cognitive communication deficit. The 06/17/26 "Functional Capacity Screen" (FCS) identified R5 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, and management of medications and treatments. R5 was incontinent of bladder and had short-term memory, memory/recall and decision-making cognitive difficulties. She was sometimes understandable and usually understood others during communication. The 05/04/26 "Negotiated Service Agreement" (NSA) identified R5 received physical assistance by facility staff with bathing, dressing, toileting, transfers, and with a wheelchair for long distances for walking/mobility. She received nurse delegation per physician's orders for management of medications and treatments and wore incontinence products supplied by the facility for bladder incontinence. Staff spoke to her in a calm voice and watched for gestures that might tell them what R5 tried to say and allowed time for her to respond for communication. The 09/15/26 at 01:14 PM "Nurses Note" documented R5 continued on an antibiotic medication for a urinary tract infection. She participated in an activity in the front common area of the facility with other residents.	S3261		

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S3261	Continued From page 5 R5's record lacked evidence of documentation of "Nurses Notes" after 09/15/26. On 09/30/26 at approximately 02:28 PM Administrative Nurse C stated R5 deceased on 09/16/26 and confirmed her record lacked evidence of documentation of all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions - Record Review for R8 revealed an admission date of 03/06/25 with diagnoses of dementia and altered mental status. The 07/09/25 "FCS" identified R8 required physical assistance with bathing, dressing, toileting, and was unable to perform management of medications and treatments. She was incontinent of bladder and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. The 07/29/25 "NSA" identified R8 received physical assistance by facility staff with bathing, dressing, and toileting. She received nurse delegation per physician's orders for management of medications and treatments and wore incontinence products supplied by the facility for bladder incontinence. R8 resided in a secured memory-care unit and facility staff broke tasks into smaller tasks and kept routine constant as much as possible for cognitive difficulties. The 07/10/26 at 12:34 PM "Nurses Note" documented R8 reported to facility staff she did not feel well. She appeared pale and was not able to stand up without assistance according to her baseline, had low blood pressure, and transferred to the hospital.	S3261		

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S3261	Continued From page 6 R8's record lacked evidence of documentation of "Nurses Notes" after 07/10/26. On 09/30/26 at approximately 02:45 PM Administrative Nurse B confirmed R8's record lacked evidence of documentation of all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions after she transferred to the hospital on 07/10/26. - Record Review for R9 revealed an admission date of 02/06/25 with diagnoses of Alzheimer's and Parkinson's disease. The 07/31/25 "FCS" identified R9 was unable to perform management of medications and treatments and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. The 07/31/25 "NSA" identified R9 received nurse delegation per physician's orders for management of medications and treatments. She resided in a secured memory-care unit and facility staff broke tasks into smaller tasks and kept routine constant as much as possible for cognitive difficulties. The 08/16/25 at 07:48 PM "Nurses Note" documented R9 had a non-injury fall with two unidentified family members present. One family member expressed concern that R9 may be experiencing pain and wanted R9 transferred to the hospital for evaluation. The 08/17/25 at 06:06 PM "Nurses Note" documented R9 was still at the hospital.	S3261		

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S3261	Continued From page 7 The 08/19/25 at 12:09 PM "Nurses Note" documented the nurse called R9's unidentified family and left message requesting an update. The 08/21/25 at 09:18 AM "Nurses Note" documented the nurse called R9's unidentified family and left message. R9's record lacked evidence of documentation of "Nurses Notes" after 08/21/25 at 09:18 AM. On 09/30/26 at approximately 02:58 PM Administrative Staff A confirmed R9's record lacked evidence of documentation after she transferred to the hospital on 08/16/25 and did not return to the facility. On 09/30/26 at 02:55 PM a nursing documentation policy was requested which was not provided. The operator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the dates, times, actions taken, and results of the actions for R5, R8, and R9.	S3261			
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	S3299			

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S3299	Continued From page 8 by: KAR 26-41-206(e) The facility had a main kitchen where food was stored, prepared, and served to the residents. Based on observation, interview, and record review the facility failed to ensure designated staff stored food items under safe conditions. Findings included: - Observation on 09/28/26 at approximately 02:29 PM of kitchen refrigerators and freezers revealed the following: The freezer contained 24 plastic round containers that contained unidentifiable contents. The containers lacked labels identifying the contents and the prepared/frozen dates. The refrigerator contained a plastic container covered with plastic wrap labeled cranberry sauce and dated 09/05/26 which was 23 days at the start of the survey. Review of the kitchen refrigerator and freezer daily temperature log from for the month of September 2026 revealed the log was blank from 09/22/26 to 09/28/26 which was eight days. On 09/28/26 at approximately 02:29 PM Dietary Staff D confirmed the freezer contained containers of food items for the residents that lacked labels identifying the contents and the prepared/frozen dates, the refrigerator contained a food item that was 23 days from open/preparation date, and the refrigerator and freezer daily temperature log from for the month of September 202 was blank from 09/22/26 to 09/28/26.	S3299		

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S3299	Continued From page 9 The facility failed to ensure designated staff stored food items under safe conditions.	S3299			