STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175560	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	**12500 W 137TH ST , OVERLAND PARK, Kansas, 66221**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification survey was conducted at Colonial Village on 10/19/2026-1021/2026 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility census on the first day of the survey was 38. The sample size included 12 residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to reasonably accommodate the needs of Resident (R) 37 when her call light was not within her reach. Findings included: - R37's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R37's "Admission Minimum Data Set (MDS)" dated 07/12/2026 recorded a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS for R37 documented substantial/maximal assistance from staff with toileting and bathing. R37's "Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA)" dated 07/12/2026 documented R37 was hospitalized for urinary tract	F0558		

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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F0558 SS = D	Continued from page 1 infection with increase weakness and no longer able to care for herself. R37 was admitted to long term care on hospice services with a diagnosis of CHF. R37's "Care Plan" documented the following: 07/09/2026-Encourage and remind R37 to use call light to call for assistance, ensure call light was within her reach after providing cares and exiting her room. R37 was encouraged to turn on call light for any need including nighttime. On 10/19/2026 at 07:33 AM, R37's call light was dangling from her bed rail. R37's pillow was over the call light cord on her left side bedrail. R37 could not reach her call light. On 10/21/2026 at 11:58 AM, Certified Nurse's Aide (CNA) M stated call lights should be within the residents' reach. On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated residents call lights should be within the residents reach or clipped to the residents clothing. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated call lights should be within the reach of the resident. The facility's "Answering Call Light" dated 09/2022 documented the purpose of this procedure is to ensure timely responses to the residents' requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.	F0558		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents	F0583		

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F0583 SS = D	Continued from page 2 right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to keep Resident (R) 30's protected health information (PHI) private on a medication cart parked in the main hallway. Findings included: - On 10/21/2026 at 07:20 AM, observation revealed a medication cart parked in the main hallway outside the main dining room with a laptop computer sitting on the top. The computer screen was unlocked and open, and R30's PHI was on the screen visible to all who passed by the medication cart. The information visualized included R30's medications, date of birth, allergy information, and code status. R30's intravenous (IV-administered directly into the bloodstream via a vein) medication laid on top of the unsecured cart. No nursing staff were in view of the medication cart. Licensed Nurse (LN) G returned to the medication cart. On 10/21/2026 at 07:24 AM, LN G stated the medication cart should have been locked, and the computer screen should also have been locked. She stated that she should not have left R30's IV medication unsecured. On 10/21/2026 at 12:45 PM, Administrative Nurse D stated he expected medication cart to be locked with the resident's medications locked inside the cart. He stated the computer should also be locked when	F0583		

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F0583 SS = D	Continued from page 3 nurses are not at the cart working. Administrative Nurse D stated that it was LN G agency's first day at the facility. The facility's "Privacy and Security of Confidential Information Security Safeguards" policy dated 06/23/2026 documented the facility was committed to protecting the privacy and security of residents' Health Information and other personally identifiable information.	F0583		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.	F0605		

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F0605 SS = D	Continued from page 4 . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F0605		

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F0605 SS = D	Continued from page 5 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure Resident (R)37and R3 were free from unnecessary medications when staff failed to ensure the as needed (PRN) lorazepam (anti-anxiety) orders had a 14-day stop date of a specified duration with a documented physician ration for extended use. Findings included: - 1. R37's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R37's "Admission Minimum Data Set (MDS)" dated 07/12/2026 recorded a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R37 did not receive antianxiety (a class of medications that calm and relax people) the lookback period. medication during the R37's "Functional Abilities (Self-Care Mobility) Care	F0605		

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F0605 SS = D	Continued from page 6 Area Assessment (CAA)" dated 07/12/2026 documented R37 was hospitalized for urinary tract infection with increased weakness and no longer able to care for herself. R37 was admitted to long term care on hospice services with a diagnosis of CHF. R37's "Care Plan" documented the following: 07/09/2026-R37 was receiving medications with Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) and was at risk for adverse reactions related to medication. If there was more than one prescribing physician, nursing was to ensure that each physician had the full list of medications available. Staff were to monitor R37 for falls, weight loss, fatigue, lethargy, and confusion. R37's EMR under the "Orders" tab revealed the following physician order: Lorazepam oral concentrates two milligrams(mg) per one milliliter (ml), give 0.25 ml by mouth every four hours as needed for agitation/restlessness and give 0.25ml by mouth every hour as needed for anxiety or agitation dated 10/02/2026. R37's EMR lacked a 14-day stop date or specified duration with physician rationale. On 10/19/2026 at 07:18 AM, R37 laid on her bed, her bed was in a high position with a fall mat beside her bed. On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated the nurse taking the order should recognize the order for lorazepam did not have a 14 day stop date and follow up with the prescribing physician. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated he was unaware the facility needed to have a 14 day stop date on the first time a psychotropic medication was ordered if the physician stated to continue the medication for an indefinite duration. The facility did not provide a policy for psychotropic drug use as requested on 10/21/2026. 2. R3's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of chronic pain, dementia (a progressive mental disorder characterized by failing memory and confusion),	F0605		

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F0605 SS = D	Continued from page 7 anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and constipation. The "Significant Change Minimum Data Set (MDS)" dated 07/17/2026 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R3 had received anticoagulant (a class of medications sued to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The MDS documented R3 had received as needed antipsychotic medication, there was no physician documentation a gradual dose reduction was contraindicated during the observation period. R3's "Psychotropic Drug Use Care Area Assessment (CAA)", dated 07/23/2026 documented she had several falls. She yelled out at times and could be resistive to staff when assisting her with personal care. R3 's "Care Plan," documented the following interventions: 06/16/2024 – Staff would administer her medications as ordered. Staff would monitor and document any side effects and effectiveness. Date Initiated: 06/16/2024 R3's EMR under the "Orders" tab revealed the following physician orders: Lorazepam oral concentrates 2 milligram (mg)/milliliters (ml), give 0.25 ml by mouth every hour as needed for agitation or restlessness dated 08/06/2026. The medication order lacked a stop date. Review of R3's EMR revealed a "Monthly Medication Review (MMR)" dated 08/31/2026, documented a 30 day stop date. MMR was signed by the physician dated 09/03/2026. The facility provided a "Hospice Physician" order dated 10/12/2026 documented to discontinue automatic discontinuation protocol for as needed	F0605		

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F0605 SS = D	Continued from page 8 medication due to non-use within 14 days. All currently ordered as needed medications are to remain active and available for administration as prescribed, regardless of frequency of use, unless specifically discontinued by the hospice physician On 10/19/2026 at 10:19 AM, R3 laid in her bed in a low position, she yelled for help several times. R3 yelled at writer to help her. R3 stated she needed to have a bowel movement. On 10/21/2026 at 12:39 PM, R3 propelled her wheelchair with her lower extremities down the hallway toward the dining room asking staff and visitors for help she needed to go to the bathroom and then stated she needed to go to the hospital. Nursing staff assisted her back to her room and assisted her to the bathroom. On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated the nurse taking the order should recognize the order for lorazepam did not have a 14 day stop date and follow up with the prescribing physician. LN H stated it was Administrative Nurse D and Administrative Nurse E responsibility to review the residents' psychotropic medications, they would ensure the orders had duration, consent for treatment and a correct diagnosis for administration. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated he was unaware the facility needed to have a 14 day stop date on the first time an antipsychotic medication was ordered, if the physician stated to continue the medication for an indefinite duration.	F0605		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer,	F0640		

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F0640 SS = D	Continued from page 9 reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to complete and transmit an accurate Minimum Data Set (MDS) for Resident (R) 32 within 14 days after discharge from the facility. Findings included:	F0640		

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F0640 SS = D	Continued from page 10 - R32's Electronic Medical Record (EMR) from the "Progress Note" tab revealed a "Discharge Summary" note dated 06/07/2026, which documented he was discharged home. Review R32's EMR under the "MDS" tab revealed the last completed and accepted MDS was an "Entry MDS" dated 07/28/2026 had been completed and accepted. A "Medical 5-Day MDS" dated 06/03/2026, had been completed and a "Discharge Return Not Anticipated MDS" dated 06/07/2026 was completed. On 10/21/2026 at 11:45 PM, Administrative Nurse E stated the MDS had been checked as not to be submitted. She stated she would send the MDS. The facility's undated "Electronic Transmission of the MDS" policy documented all MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records would be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data.	F0640		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable	F0657		

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F0657 SS = D	Continued from page 11 for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to revise Resident (R)4's comprehensive "Care Plan" to include R4's suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) cares. Findings included: - R4's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of CHF, and fracture of femur (thigh bone). The "Significant Change Minimum Data Set" (MDS) for R4 dated 09/26/2026 recorded a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R4 had an impairment on one side of her body. The MDS documented R4 had a catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). R4's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 09/26/2026 documented R4 was admitted from the hospital. R4 was working with therapy for ambulation. The CAA documented R4 required assistance with all activities of daily living (ADLs). R4's "Care Plan" documented the following: 08/13/2026-R4 was totally dependent on one staff for toilet use. R4 had a suprapubic catheter that needed emptied daily. R4's "Care Plan" lacked staff direction for the care of R4's suprapubic catheter. R4's EMR documented the following physician orders: Change catheter drainage bag weekly and as needed every night shift every Friday dated 09/24/2026 Catheter care: change catheter secure site every five days and as needed dated 09/24/2026.	F0657		

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F0657 SS = D	Continued from page 12 Suprapubic catheter 16 French, 10 milliliter balloon dated 09/26/2026. Change catheter drainage bag weekly and as needed every night shift every Friday, dated 09/24/2026 On 10/19/2026 at 07:52 AM, R4 sat in her chair in her room. R4's suprapubic catheter drainage bag laid on the floor beside her walker. On 10/21/2026 at 11:58 AM, Certified Nurse's Aide (CNA) M stated she would be able to tell how to take care of R4's catheter by asking a nurse or looking in R4's Kardex (nursing tool that gives a brief overview of the care needs of each resident). On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated R4's suprapubic cares should be on the care plan. She stated nurses could see the orders in the "Treatment Administration Record" (TAR), and the CNAs would see how to care for R4's catheter in the Kardex, which flows from the plan of care. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated cares for suprapubic should be placed in the resident's care plan. He stated the Administrative Nurse E does the care plans. He stated all nurses have access to the care plan, and the CNAs have access to the Kardex. The facility's "Care Plan, Comprehensive Person-Centered" policy undated, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the residents physical, psychosocial, and functional needs was developed and implemented for each resident.	F0657		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F0686		

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F0686 SS = D	Continued from page 13 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure pressure-reducing measures were implemented for Resident (R)41 when staff failed to apply her Podus (a specialized ankle-foot orthosis (AFO) designed primarily for bedridden or immobile patients to maintain neutral foot alignment and protect the lower extremities) boot per her orders and plan of care. Findings included: - R41's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) with hemiparesis/hemiplegia (weakness and paralysis on one side of the body), affecting the right dominant side, aphagia (loss of the ability to swallow), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The "Quarterly Minimum Data Set" (MDS) for R41 dated 10/12/2026 recorded a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R41 was at risk for developing pressure ulcer/injury. The MDS documented that R41 had no pressure injuries. R41's "Pressure Ulcer/Injury Care Area Assessment" (CAA) dated 04/09/2026 documented R41 had a stroke with right side hemiparesis, and aphasia presenting for admission to long term care. R41 had residual right hemiparesis with swelling of the right hand managed with an insulated glove for compression, and a right arm sling during the day. R41 used boots for heel protection, Skin-prep (liquid skin protectant) for prior wounds, and barrier cream with incontinence. R41's "Care Plan" documented: 04/15/2026-R41 was at risk for the development of pressure ulcers related to impaired mobility, and incontinence of bowel and bladder. Staff were to administer treatments as ordered and monitor for effectiveness, barrier cream to buttocks per ordered	F0686		

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F0686 SS = D	Continued from page 14 with incontinent episodes. R41 requires pressure relieving mattress and cushion to wheelchair, bilateral boots, and splint to right hand at bedtime. R41's EMR under "Orders" documented the following physicians' orders: Place Podus boots bilaterally when in bed every day and night shift dated 09/05/2026. R41's "Braden Scale for Predicting Pressure Ulcer Risk Evaluation" dated 07/26/2026 documented a score of 15 indicating R41 was at risk for pressure injury. On 10/19/206 at 08:01 AM, R41 laid on her bed covered with a blanket, R41 was not wearing boots on her feet. On 10/20/2026 at 01:45 PM, R41 lay on her bed listening to her IPAD. R41 was not wearing boots on her feet. On 10/21/2026 at 11:58 AM, Certified Nurses Aide (CNA) M stated she would know by looking at the residents Kardex (nursing tool that gives a brief overview of the care needs of each resident), who needed boots applied to their heels when in bed. She stated all clinical staff could apply boots to a resident. On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated if a resident needed boots while in bed, that would be a physician's order on the "Treatment Administration Record" (TAR) and the nurse would ultimately be responsible for ensuring resident's had boots if ordered. She stated the CNAs would also know if a resident needed boots by looking at the residents Kardex. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated anyone with boots there would be an order on the TAR. He stated the CNAs could refer to the Kardex to see if a resident needed boots. He stated if a resident had as order for boots, he would expect the boots to be on the resident as ordered. The facility's "Prevention of Pressure Ulcer/Injuries" dated 07/2017, documented the purpose of this procedure was to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors, repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences.	F0686		

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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 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 fall interventions aimed to prevent further falls were implemented per Resident (R) 5's plan of care. Findings included: - R5's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of muscle weakness, need for assistance with personal care, repeated falls, and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The “Quarterly Minimum Data Set (MDS)” dated 08/18/2026 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R5 had falls with two or more injury falls during the observation period. R5's "Falls Care Area Assessment (CAA)”, dated 05/31/2026, documented he had progressive dementia and required staff assistance with daily cares due to weakness. He had a history of falls. R5's “Care Plan,” documented the following interventions: 11/22/2025 - Dycem (non-slip mat used for stabilization and gripping to prevent slipping) in his recliner. 06/08/2026 – Staff would ensure his shoes are tied and not loose fitting. On 10/19/2026 at 10:20 AM, R5 sat in his recliner	F0689		

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F0689 SS = D	Continued from page 16 without his shoes on. R5's shoes laid under his bed. On 10/20/2026 at 12:36 PM, R5's recliner lacked the Dycem in his recliner. On 10/21/2026 at 11:58 AM, Certified Nurse Aide (CNA) M stated she did not consider R5 a high fall risk at this time. She stated R5 had fallen frequently, but since staff placed his wheelchair next to his recliner had not fallen. CNA M had access to the resident's care plan. She stated the fall interventions could be found on the care plan or Kardex (nursing tool that gives a brief overview of the care needs of each resident). On 10/21/2026 at 12:15 PM, Licensed Nurse (LN) H stated she was not sure if R5 was a high fall risk. LN H stated everyone had access to each of the president's plan of care of the Kardex. LN H stated the interdisciplinary team (IDT) would review each fall and ensure there was an intervention after each fall placed on the care plan. On 10/21/2026 at 12:45 PM, Administrative Nurse D stated R5 was definitely a high fall risk. He stated R5 had not fallen recently. Administrative Nurse D stated it was everyone's responsibility to ensure fall interventions were in place. The facility's undated "Description of Fall Prevention Program" policy documented a "Fall Risk Evaluation Assessment" was used to assess residents for fall risk upon admission and as needed. Individualized fall prevention approaches would be care planned for residents at risk of falls and residents who have fallen based on assessment. Each fall was reviewed by the IDT team, and new interventions would be discussed and implemented.	F0689		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F0757		

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F0757 SS = D	Continued from page 17 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure Resident (R) 4's drug regiment was free from unnecessary medication when the facility failed to consistently notify the physician of R4's antihypertensive (a class of medication used to treat high blood pressure) medication were held multiple times. Findings Included: - R4's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), and fracture of femur (thigh bone). The "Significant Change Minimum Data Set" (MDS) for R4 dated 09/26/2026 recorded a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R4 had an impairment on one side of her body. The MDS documented R4 had heart failure and hypertension. R4's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 09/26/2026 documented R4 was readmitted by the hospital. The CAA documented R4 working with therapy with ambulation and does require assistance with activities of daily living (ADLs). The CAA documented R4's recent hospital stay was due to CHF exacerbation. R4's "Care Plan" documented the following: 08/13/2026- R4 was a weekly weight, staff should weigh R4 before breakfast. R4 had an altered cardiovascular (relating to the	F0757		

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F0757 SS = D	Continued from page 18 heart and blood vessels) status, and hypertension. Staff were to educate R4 about the importance of limiting salt in her diet. Give anti-hypertensive medications as ordered, and report to physicians as needed. R4's EMR under the "Orders" tab revealed the following physician orders: Losartan potassium (anti-hypertensive medication) oral tablet 25 milligrams (mg), one table by mouth in the morning for heart failure. Hold if the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) pressure was less than (<) 110 dated 09/24/2026. Metoprolol succinate ER (anti-hypertensive medication) oral tabled extended-release 24 hours Give 25 mg, one table by mouth in the morning for heart failure. Notify physician for systolic blood pressure greater than 180 or less than 110 dated 09/24/2026. R4's October 2026 "Medication Administration Record" (MAR) documented R4's losartan potassium 25 mg was held for blood pressure out of parameters on 10/02/2026, 10/05/2026, 10/07/2026, 10/10/2026, 10/11/2026, 10/13/2026, 10/18/2026. R4's EMR under "Progress Notes" documented the physician was notified on 10/10/2026. On 10/19/2026 at 07:52 AM, R4 sat in her chair in her room waiting for breakfast to be delivered. On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated if a resident's medication had been held several times, the nurse on duty should reach out to the physician. She stated the nurse should pass the medication help in report. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated he would expect the physician to be called with an antihypertension medication being held several times. He stated the nurse who was on duty would be the nurse to call the physician. He stated the facility did a huddle every morning, and he would expect that information to be passed on to department heads for follow up. The facility did not provide an unnecessary medication policy as requested on 10/21/2026.	F0757		

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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 interviews, observation, and record review, the facility failed to discontinue Resident (R)3's as needed psychotropic (alters mood or thought) medication after the 30-day automatic stop date order expired, resulting in unauthorized administration beyond the prescribed stop date. Findings included: - R3's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of chronic pain, dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and constipation. The "Significant Change Minimum Data Set (MDS)" dated 07/17/2026 documented a Brief Interview of Mental Status (BIMS) score of two, which indicated severely impaired cognition. The MDS documented R3 had received anticoagulant (a class of medications sued to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The MDS documented R3 had received as needed antipsychotic medication, there was no physician documentation a gradual dose reduction was contraindicated during the observation period. R3's EMR under the "Orders" tab revealed the following physician orders: Lorazepam (psychotropic) oral concentrates 2 milligram (mg)/milliliters (ml), give 0.25 ml by mouth every hour as needed for agitation or restlessness dated 08/06/2026. The medication order lacked a stop date.	F0760		

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F0760 SS = D	Continued from page 20 Review of R3's EMR revealed a "Monthly Medication Review (MMR)" dated 08/31/2026, documented a 30 day stop date. MMR was signed by the physician dated 09/03/2026. Review of R3's "Medication Administration Record (MAR)" and "Treatment Administration Record (TAR)" from 09/06/2026 to 10/19/2026 (43 days), her as needed lorazepam was administered 48 times after the 30 days stop date. The facility provided a "Hospice Physician" order dated 10/12/2026 documented to discontinue automatic discontinuation protocol for as needed medication due to non-use within 14 days. All currently ordered as needed medications are to remain active and available for administration as prescribed, regardless of frequency of use, unless specifically discontinued by the hospice physician. On 10/19/2026 at 10:19 AM, R3 laid in her bed in a low position, she yelled for help several times. R3 yelled at the writer to help her. R3 stated she needed to have a bowel movement. On 10/21/2026 at 12:39 PM, R3 propelled her wheelchair with her lower extremities down the hallway toward the dining room asking staff and visitors for help she needed to go to the bathroom and then stated she needed to go to the hospital. Nursing staff assisted her back to her room and assisted her to the bathroom. On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated the nurse taking the order should recognize the order for lorazepam did not have a 14 day stop date and follow up with the prescribing physician. LN H stated it was Administrative Nurse D and Administrative Nurse E responsibility to review the residents' psychotropic medications, they would ensure the orders had duration, consent for treatment and a correct diagnosis for administration. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated he was unaware the facility needed to have a 14 day stop date on the first time an antipsychotic medication was ordered, if the physician stated to continue the medication for an indefinite duration. Administrative Nurse D stated it would not be a medication error for the continued to administer R3's as needed Ativan without a current because she had an order prior to the stop date and would only need to be reinstated.	F0760		

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F0760 SS = D	Continued from page 21 Upon request, a policy was not provided.	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to store medications and biologicals within professional standards of practice when the facility failed to secure Resident (R) 30's intravenous (IV-administered directly into the bloodstream via a vein) medication. The facility also failed to secure the medication cart. Findings included: - On 10/21/2026 at 07:20 AM, a medication cart parked in the main hallway outside the main dining room with R30's IV medication was found on the top of an unsecured medication cart. No nursing staff were in view of the medication cart. Licensed Nurse (LN) G agency returned to the medication cart. On 10/21/2026 at 07:24 AM, LN G stated R30's IV	F0761		

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F0761 SS = D	Continued from page 22 medication should have been locked inside the locked medication cart. LN G she should not have left the cart unsecured. On 10/21/2026 at 12:45 PM, Administrative Nurse D stated he expected medication cart to be locked with the resident's medications locked inside the cart. Administrative Nurse D stated that it was LN G agency's first day at the facility. The facility's undated "Storage of Medications" policy documented the facility stored all drugs and biologicals in a safe, secure, and orderly manner.	F0761		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175560	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	**12500 W 137TH ST , OVERLAND PARK, Kansas, 66221**

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F0880 SS = D	Continued from page 23 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews, the facility failed to establish and maintain an effective infection prevention and control program to prevent the potential spread of infection when staff failed to ensure Residents (R)4's suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) bag was not placed on the floor. The facility also failed to ensure respiratory equipment was stored in a sanitary manner for R4's nasal cannula and R28's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). Findings Included:	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175560	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2026

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F0880 SS = D	Continued from page 24 - On 10/19/2026 at 07:20 AM, during the facility walk through a nasal cannula was wrapped around the handle of a portable oxygen cylinder that was in the back of R4's wheelchair in her room. R4's nasal cannula was not in a container. R4's urinary catheter bag laid on the floor next to her walker. R28's CPAP mask hung out her top draw of her bedside table. The mask was not in a container. On 10/21/2026 at 11:58 AM, Certified Nurse Aide (CNA) M stated CPAP mask and nasal cannula's not in use should be placed in a bag labeled with the resident's name. She stated all nursing staff could place the respiratory equipment in their bags. CNA M stated catheter bags should hang below the resident's waist and never on the floor. On 10/21/2026 at 12:13 PM, Licensed Nurse (LN) H stated respiratory equipment should be placed in a bag in the resident's room. She stated it was a nursing responsibility to ensure respiratory equipment was stored in a sanitary manner. LNH stated catheter bags should be placed below the waistline and kept off the floor. On 10/21/2026 at 12:42 PM, Administrative Nurse D stated respiratory equipment was to be placed in a bag in the residents rooms. He stated catheter bags should be kept off the floor unless the bag was not able to be off the floor, and there was to be a chuck placed between the catheter bag and the floor. The facility's "Respiratory Equipment-Cleaning and Storage" undated documented respiratory equipment, including CPAP, BiPAP, masks, tubing, and related supplies, would be cleaned, maintained, and stored in a safe and sanitary manner to minimize contamination and ensure readiness for resident use. The facility's "Catheter Care, Urinary" dated 09/2014 documented the urinary drainage bag must be always held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder, and should not break aseptic technique.	F0880		