STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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 199731 and 200012 at the above named assisted living conducted on 10/08/26 and 10/12/26. The facility reported a census of 41 residents. The sample included four residents.	S 000		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) Based on interview and record review the facility failed to provide evidence of documentation that residents and staff received routine quarterly reviews of the facility's emergency management	S3280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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
S3280	Continued From page 1 plan. Findings included: - Review of the facility's emergency management plan lacked evidence of documentation residents and staff received quarterly reviews of the emergency management plan for the first, second, and third quarters of 2026. On 10/13/26 at 04:05 PM Administrative Staff A confirmed the facility lacked documentation that residents and staff received quarterly reviews of the emergency management plan for the first, second, and third quarters of 2026. The 01/22/24 facility's "Emergency and Disaster" policy documented each administrator would ensure disaster and emergency preparedness by ensuring the performance of quarterly reviews of the emergency management plan with employees and residents. The facility failed to provide evidence of documentation that residents and staff received quarterly reviews of the facility's emergency management plan.	S3280		
S3305 SS=E	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements:	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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
S3305	Continued From page 2 (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207(a) Based on observation and interview the facility failed to ensure staff provided a safe environment for residents by storing potentially harmful personal belongings away from resident areas. Findings included: - Observation on 10/12/26 at approximately 02:12 PM of the facility's activity room for the residents	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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
S3305	Continued From page 3 revealed a can of nicotine pouches on the table. Resident (R) 5 ambulated independently and entered the activity room. No staff were nearby. On 10/12/26 at 02:13 PM Certified Nurse Aide (CNA) E confirmed the can of nicotine pouches was his and he had not put it away yet after his break. Review of the policies provided by the facility revealed storage of staff personal belongings was not addressed. The facility failed to ensure staff provided a safe environment for residents by storing potentially harmful personal belongings away from resident areas.	S3305		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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
S3310	Continued From page 4 by: KAR 26-41-207(c) Based on interview and record review the facility failed remain in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for two of five sampled staff. Findings included: - Review of Administrative Nurse B's employee record revealed a hire date of 09/16/26. Her record lacked evidence of documentation she received TB infection testing. Review of Certified Medication Aide (CMA) F's employee record revealed a hire date of 09/03/26. Her record lacked evidence of documentation she received TB infection testing. On 10/12/26 at 04:05 PM Administrative Staff A confirmed Administrative Nurse B and CMA F's records lacked evidence of documentation of TB infection testing. The 01/22/24 facility's "Infection Control: Standard Precautions" policy did not address tuberculosis screening. The June 2013 department's "Tuberculosis (TB) Guidelines for Adult Care Homes" documented each new employee, and each new resident should receive a two-step TB skin within seven days of employment. The facility failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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
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. 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 maintain the Packaged Terminal Air Conditioner (PTAC) systems in at least four apartments to protect the health and safety of the residents. Findings included: - Observation on 10/12/26 at approximately	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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
S3320	Continued From page 6 01:33 PM revealed a PTAC unit in apartment 12 with a loose top section. The top section had a dark-colored substance on the inside near the top-facing air blower. On 10/12/26 at 01:51 PM Administrative Staff A and Administrative Nurse D confirmed the PTAC unit in apartment 12 required cleaning and maintenance. The state surveyor requested a cleaning and maintenance schedule for the facility's PTAC units. Observation on 10/12/26 at approximately 01:55 PM revealed the following: A PTAC unit in apartment number 1 had a loose top section. The top section had a dark-colored substance and what appeared to be a 2 x 2 inch strip of loose fiberglass insulation on the inside near the top-facing air blower. A PTAC unit in apartment 17 had a front facing filter that appeared clogged with a build-up of debris. A PTAC unit in apartment number 3 in the memory care had a dark-colored substance on the outside near the top-facing air blower grille. On 10/12/26 at approximately 01:55 PM Administrative Staff A and Administrative Nurse D confirmed the PTAC units in apartments numbered 1, 17, and 3 in the memory care required cleaning and maintenance. On 10/12/26 at 03:00 PM Administrative Nurse D stated maintenance staff informed her the PTAC units were closed systems similar to duct systems and did not require routine cleaning and maintenance.	S3320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046068	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OVERLAND PARK OPERATIONS LL	11701 NIEMAN ROAD OVERLAND PARK, KS 66210

(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
S3320	Continued From page 7 Review of the policies provided by the facility revealed cleaning and maintenance of the facility's PTAC units was not addressed. The facility failed to maintain the PTAC systems in at least four apartments to protect the health and safety of the residents.	S3320		