STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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 #194680, #192503, #192536, #192371, #192699, #191443, #191165, #190476, #189840, #189366, #188755, #186970, #182783, #195060 and #182214 at the above named assisted living conducted on 04/08/25, 04/14/25-04/16/25, 04/21/25, 04/22/25 and 04/29/25	S 000		
S3026 SS=J	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: KAR 26-41-101(f)(1)(B) The facility reported a census of 38 residents with three residents included in the sample and 13 focused reviews. Based on observation, interview, and record review the administrator failed to protect Resident (R) 3 from neglect by the failure to secure all exit doors. On 07/18/24 at approximately 05:50 PM cognitively impaired R3 exited the facility through an unsecured door to the outside without staff knowledge. Facility staff found R3 approximately 10 minutes later on	S3026		

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
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

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S3026	Continued From page 1	S3026		

the sidewalk near the parking lot of the facility where he walked toward a heavily traveled six-lane street. This placed R3 in Immediate Jeopardy.

Findings included:

- Record review for R3 revealed an admission date of 05/20/24 with a diagnosis of dementia.

The 09/04/24 (107 days after admission)Functional Capacity Screen "FCS" documented next to the transfers and walking/mobility lines the letter "I." The "FCS" identified R3 had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; was rarely or never understandable and sometimes understood others during communication; was at risk for falls, wandering, and inappropriate behaviors.

The 10/17/24 (150 days after admission) Negotiated Service Agreement "NSA" identified R3 was independent with transfers and may require escort with a device for walking/mobility. Facility staff monitored and assisted as needed for safety for cognitive difficulties, provided "frequent checks" to prevent falls, attempted to engage him in purposeful activities for wandering; and provided behavior mapping with appropriate interventions for behaviors. The "NSA" lacked a description of services provided for communication.

Review of R3's record lacked evidence that facility staff conducted a "FCS" on or before admission and developed a "NSA" at admission.

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

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S3026	Continued From page 2	S3026		

The 05/21/24 "Nursing Admission Evaluation Results and Service Plan" documented R3 had a history of wandering, may wander outside, and health and safety may be jeopardized.

The 05/20/24 at 10:55 AM nursing "Progress Note" documented R3 moved into the facility.

The 07/14/24 at 06:55 PM nursing "Progress Note" documented R3 had a few episodes of aggressive behavior and did not cooperate with the caregiver.

The 07/15/24 at 03:47 PM nursing "Progress Note" documented R3 slept well during the night with no behaviors exhibited during the shift.

The 07/16/24 at 08:02 PM nursing "Progress Note" documented R3 was calm with no behaviors observed during the evening.

The 07/19/24 at 09:06 PM nursing "Progress Note" documented R3 was calm and cooperated well with staff.

The 07/21/24 at 11:43 AM nursing "Progress Note" documented facility staff found R3 on the ground outside the patio door.

Review of nursing "Progress Notes" from 07/01/24 to 07/22/24 lacked documentation when R3 was outside of the facility without staff knowledge on 07/18/24.

The 07/26/24 facility's "Investigation Report" to the department by Administrative Staff J documented the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3026	Continued From page 3	S3026		

1) On 07/18/24 facility staff last observed R3 in a common area in the facility at 05:50 PM.
2) At approximately 06:00 PM Certified Nurse Aide (CNA) K observed R3 in the facility's parking lot and assisted him back inside the building.
3) Facility staff reviewed video footage which revealed R3 exited a side door on the east side of the building.
4) The side door on the east side of the building had a screw that lifted out of place on the threshold of the door. The magnetic lock could not engage and secure the door.

The 12/19/24 at 11:10 PM "Elopement Documentation Form" documented Maintenance Staff D conducted an elopement drill with three staff in attendance.

The 01/21/25 at 10:55 AM "Elopement Documentation Form" documented Maintenance Staff D conducted an elopement drill with 18 staff in attendance.

Review of facility provided daily "Morning Sweep Check List" included a line to check magnetic locks and doors for proper operation. The "Morning Sweep Check List" first date documented as complete with no issue,s was on 11/13/24 which was 118 days after R3 exited the facility without staff knowledge. Review of the "Morning Sweep Check List" from 11/13/24 to 04/13/25 revealed staff documented doors and locks checked daily to ensure they were secure with the following exceptions:

November 2024 - lacked evidence of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3026	Continued From page 4	S3026		

documentation facility staff checked exit doors on 11/16/24, 11/17/24, and from 11/22/24 to 11/30/24 which was 11 days.

December 2024 - lacked evidence of documentation facility staff checked exit doors from 12/01/24 to 12/28/24 and on 12/31/24 which was 29 days.

January 2025 - lacked evidence of documentation facility staff checked exit doors for the whole month which was 31 days.

February 2025 - lacked evidence of documentation facility staff checked exit doors for the whole month which was 28 days.

March 2025 - lacked evidence of documentation facility staff checked exit doors for the whole month which was 31 days.

April 2025 - lacked evidence of documentation facility staff checked exit doors from 04/01/25 to 04/12/25 which was 12 days.

Observation on 04/08/25 at 10:30 AM revealed the side door on the east side of the building was alarmed and locked.

On 04/16/25 at 10:55 AM Administrative Staff A confirmed facility's investigation lacked witness statements from staff present on 07/18/24 when R3 exited the building without staff knowledge. Administrative Staff A stated she was not employed at the facility on 07/19/24.

On 04/16/25 at 11:15 AM Administrative Staff A stated Maintenance Staff D documented exit

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3026	Continued From page 5	S3026		

doors checked daily when he began working at the facility in November 2024. She could not find documentation facility staff checked exit doors to ensure they were secure prior to November 2024.

On 04/16/25 at 12:30 PM Licensed Nurse F stated during a phone interview he worked in the facility on 07/18/24. He checked all the exit doors and they were secured. He did not know how R3 got out of the building.

On 04/16/25 at 12:40 PM (Certified Nurses Aide) CNA K stated during a phone interview she worked in the facility on 07/18/24. She took out the trash and saw R3 near the street and had no idea how he got out of the building. CNA K could not recall if any doors at the time were not secure due to maintenance issues.

On 04/16/25 at 12:49 PM CNA L stated during a phone interview she worked in the facility on 07/18/24. She had clocked out and was on her way to her car. She saw R3 on the east side of the building on the sidewalk in the parking lot walking toward the street. CNA L did not know how R3 exited the building. Staff checked all exit doors immediately after R3 got out and they were all secured.

Observation on 04/16/25 at approximately 01:07 PM revealed the square-shaped building had doors that exited to an outdoor secured courtyard in the center of the facility and doors that exited outside to unsecured areas. R3's apartment was on the west side of the building. The common area where facility staff last saw R3 before he exited the building was on the east

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3026	Continued From page 6	S3026		

side of the building. Administrative Staff A used the keypad to unlock the door which led out to a breezeway area. There was not a threshold at the bottom of the door opening with screws. The smooth flooring continued into the breezeway area. Approximately five steps from the door through the breezeway was a second unsecured door that opened to the outside. A sidewalk was on the other side of the parking lot which curved around a corner and continued east toward the street. The street appeared heavily traveled with four lanes plus two turning lanes and speed limit of 45 miles per hour (mph).

On 04/16/25 at 01:41 PM Administrative Nurse B stated she worked at the facility but was not present on 07/18/24. Facility staff were not aware the east side door was unsecured until R3 was able to go through the door. They did not know how long the door had been unsecured. Administrative Staff B was not aware if staff checked the exit doors to ensure they were secured prior to R3 exiting the building without staff knowledge. After R3 got out, a sign was put on the door that read "Do Not Use" until the door was repaired. Administrative Nurse B did not know when the door was repaired and secured again.

On 04/16/25 at 03:57 PM Administrative Staff A stated the corporate office contacted Administrative Staff J (who no longer worked at the facility). Administrative Staff J told Corporate Staf,f R3 was able to exit out the east side door because it was temporarily unsecured. A screw was loose in the strike plate of the door latch that prevented the door from closing all the way. The door was fixed immediately by maintenance staff.

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3026	Continued From page 7 She drove to the facility later in the evening on 07/18/24 and ensured the door was secured. On 04/21/25 at 03:46 PM Administrative Nurse B stated the facility's form titled "Service Plan" was the "NSA." Observation on 04/21/25 at approximately 04:12 PM revealed R3 ambulated in common area and stopped at the door to the conference room. A receptionist sat at the front desk. Observed no other staff were present monitoring or attempting to engage R3 in meaningful activities for wandering according to his "NSA." On 04/21/25 at approximately 04:12 PM Administrative Staff stated "That's what he (R3) does. He walks around and checks all the doors." On 04/22/25 at 11:23 AM Administrative Nurse B stated she expected direct-care staff to recognize a resident was exit-seeking if one became restless, tried to open doors, or verbalized they wanted to leave or go home. The "frequent checks" described in the "NSA" meant facility staff were to check on R3 every two hours. The checks were not documented unless a check resulted in a toileting or brief change activity, or an exception or concern was reported to the nurse. On 04/22/25 at approximately 11:23 AM Administrative Staff A stated they left courtyard doors unlocked daily until 05:00 PM in case residents wanted to walk outside in a secured area. If one of the doors opened when R3 tried it, he could walk outside in the secured courtyard.	S3026		

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3026	Continued From page 8 On 04/22/25 at 11:36 AM Administrative Nurse B stated the 07/23/24 nursing "Progress Note" documented R3 was on the ground in the secured courtyard area. He was not outside of the facility. The weather on 07/18/24 according to Wunderground.com was 80 degrees Fahrenheit with a wind speed of zero mph at 05:53 AM. It was still daylight. The facility's 12/19/24 "Elopement" policy documented the facility would identify residents who were at risk of elopement and strive to prevent harm. An elopement occurred when a cognitively impaired condition left the facility unsupervised. A licensed nurse would develop an individualized interdisciplinary plan of care and updated as necessary for any resident assessed at risk of elopement. The administrator failed to protect R3 from neglect by the failure to secure all exit doors. Cognitively impaired R3 exited the facility through an unsecured door to the outside without staff knowledge. Facility staff found R3 on the sidewalk near the parking lot of the facility walking toward a heavily traveled street six-lane street. Jeopardy was removed on 07/18/24 at 06:30 PM when the following actions were documented by the facility in the "Abatement Plan" and accepted by the department on 04/16/25 at 05:10 PM. 1) Facility staff checked all exit doors immediately, building and completed a head	S3026		

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3026	Continued From page 9 count to ensure all residents were present and accounted for. 2) Administrative Nurse B put a sign on the east side exit door that read "Do Not Use" until further investigation. 3) At approximately 06:30 PM, Administrative Staff J discovered a screw on the strike plate of the door frame was loose which prevented the door from latching properly. The screw was resecured, the door closed with no issues, and the maglock alarm activated. 4) New Director of Plant Operations (maintenance) and new Administrator have taken positions at the facility since 07/18/25 5) Weekly door checks were implemented on 11/14/24 and documented in a log when the new Director of Plant Operations began working at the facility. Monthly elopement drills were implemented on 12/19/24. 6) A new maintenance ticket system was implemented to keep records of maintenance tasks completed.	S3026		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3028	Continued From page 10 exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(B)(C) The facility reported a census of 38 residents with three residents included in the sample and 11 focused reviews. Based on interview and record review the administrator failed to report to the department within 24 hours and conduct investigations regarding three separate occasions of resident-to-resident allegations of potential abuse. The administrator further failed to ensure facility staff took immediate measures to prevent further potential abuse on a fourth occasion when facility staff left Resident (R) 6 and R7 unsupervised in a common area when R6 exhibited restlessness, exit-seeking, and yelling behavior toward staff and residents. R7 pushed R6 who fell, hit her head, and suffered a	S3028		

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3028	Continued From page 11	S3028		

bump on her head which required transport to the hospital for further evaluation.

Findings included:

- Record review for R3 revealed an admission date of 05/20/24 with diagnoses of dementia and insomnia.

The 09/04/24 (107 days after admission) "Functional Capacity Screen" (FCS) identified R3 was unable to perform bathing, dressing, toilet, and management of medications and treatments. He was independent with transfers, walking/mobility, and eating. R3 was incontinent of bladder and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. He was rarely or never understandable and sometimes understood others during communication and was at risk for falls, impaired decision-making, wandering, and inappropriate behavior.

The 10/17/24 (150 days after admission) "Negotiated Service Agreement" (NSA) identified facility staff provided R3 assistance of two staff twice a week with bathing, assistance of two staff with dressing and toileting, and he was independent with transfers. R3 may require escort with a device for walking/mobility and may require assistance with eating. The facility provided R3 assistance of 2 staff for bladder incontinence and he was on a toileting program. Staff monitored and assisted as needed for safety for cognitive difficulties and provided frequent checks to prevent injury from falls. Staff attempted to engage R3 in meaningful activities

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S3028	Continued From page 12	S3028		

for wandering and provided behavior mapping and interventions for inappropriate behavior. The "NSA" failed to describe services provided for management of medications, treatments, and communication.

The 11/01/24 at 01:10 PM nursing "Progress Note" documented R3 walked around the community followed closely behind by another resident. The resident started touching R3 on the back. R3 became frustrated, turned around, slapped the other resident on the arm or shoulder and possibly in the face. R3 then grabbed the other resident's face.

Review of records provided by the facility revealed a lack of evidence of documentation the facility reported the incident to the department within 24 hours or conducted an investigation to rule out abuse, neglect, or exploitation.

On 04/22/25 at 12:17 PM Administrative Nurse B confirmed the incident between R3 and another resident on 11/10/24 was not reported to the department and an investigation was not started.

- Record review for R7 revealed an admission date of 06/14/23 with diagnoses of cerebral infarction and dementia.

The 0704/24 "FCS" identified R7 was unable to perform management of treatments and medications; had long-term and memory/recall cognitive difficulties; and was at risk for impaired decision-making.

The 03/31/25 "NSA" identified facility staff administered medications per physician's orders,

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3028	Continued From page 13	S3028		

monitored and assisted as needed for cognitive difficulties, and he had a durable power of attorney (DPOA) for impaired decision-making. The "NSA" failed to describe services provided for management of treatments.

The 11/11/24 at 08:32 PM nursing "Progress Note" documented R7 stood next to another resident laying on the floor. R7 stated he pushed the resident.

The 01/07/25 at 05:44 PM nursing "Progress Note" documented R7 was in a snack area when he tried to take some cups away from another resident. The other resident ended up on the ground with a skin tear.

Review of records provided by the facility revealed a lack of evidence of documentation the facility reported both incidents to the department within 24 hours or conducted investigations to rule out abuse, neglect, or exploitation.

On 04/22/25 at 01:58 PM Administrative Staff A confirmed the incident between R7 and another resident on 11/11/24 was not reported to the department and an investigation was not started.

On 04/22/25 at approximately 01:58 PM Administrative Nurse B confirmed the incident between R7 and another resident on 01/07/25 was not reported to the department and an investigation was not started.

- Record review for R6 revealed an admission date of 04/01/22 with a diagnosis of dementia.

The 12/22/24 "FCS" identified R6 required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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
S3028	Continued From page 14	S3028		

physical assistance with bathing; was unable to perform management of medications and treatments; had long-term memory and memory/recall cognitive difficulties; and was at risk for impaired decision-making and wandering.

The 09/26/24 "NSA" identified facility staff provided R6 stand-by-assistance with bathing; administered medications per physician's orders; she had a durable power of attorney (DPOA) for impaired decision-making; and facility staff redirected and engaged her in activities for wandering behavior. The "NSA" failed to describe services provided for management of treatments and cognition.

The 10/24/24 at 02:03 AM nursing "Progress Note" documented R6 was restless, exit seeking, and yelled at staff and other residents. Staff attempted unsuccessfully to redirect her. Licensed Nurse M administered an as needed calming medication and walked out of the common area. Licensed Nurse M then heard R6 and R7 yelling at each other and turned around. Licensed Nurse M observe R7 pushed R6 who fell on the floor and hit her head. R6 sustained a large bump on the right side of her forehead and was transported to the hospital for further evaluation.

On 04/21/25 at 03:46 PM Administrative Nurse B stated the facility's form titled "Service Plan" was the "NSA."

On 04/22/25 at approximately 01:37 PM Administrative Nurse B stated she expected designated staff to supervise and redirect an agitated resident and not leave them alone with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3028	Continued From page 15 other residents without supervision. The facility's "Resident Abuse: Prevention, Investigation and Reporting" policy documented prevention training included instruction to employees to identify behaviors among residents which might lead to abuse of one resident perpetrated by another resident. Facility staff reported an alleged or witnessed incidence of abuse per state guidelines. Facility staff would investigate every incident of suspected or witnessed abuse and report findings to the state licensing agency. If facility staff suspected abuse, a one-to-one caregiver may be assigned to a resident. The administrator failed to report to the department within 24 hours and conduct investigations regarding three separate occasions of resident-to-resident allegations of potential abuse. The administrator further failed to ensure facility staff took immediate measures to prevent further potential abuse on a fourth occasion when facility staff left R6 and R7 unsupervised in a common area when R6 exhibited restlessness, exit-seeking, and yelling behavior toward staff and residents. R7 pushed R6 who fell, hit her head, and suffered a bump on her head which required transport to the hospital for further evaluation.	S3028		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall	S3080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3080	Continued From page 16 conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a)(b) The facility reported a census of 38 residents with three residents included in the sample and 13 focused reviews. Based on interview and record review the administrator failed to ensure designated staff conducted a "Functional Capacity Screen" (FCS) for R3 and R7 on or before admission to the facility and failed to ensure a licensed nurse documented the assessment for R3 when his "FCS" indicated he required healthcare services. Findings included: - Record review for R3 revealed an admission date of 05/20/24 with diagnoses of dementia and insomnia. The 09/04/24 "FCS" conducted by facility staff was 107 days after admission.	S3080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3080	Continued From page 17	S3080		

The "FCS" signed by Administrative Staff J lacked evidence of documentation a licensed nurse completed the assessment.

Review of R3's record lacked evidence facility staff conducted an "FCS" on or before admission.

On 04/22/25 at 10:52 AM Administrative Nurse B confirmed R3's record lacked evidence of documentation designated staff conducted an "FCS" on or before admission and a licensed nurse completed the assessment.

- Record review for R7 revealed an admission date of 06/14/23 with diagnoses of cerebral infarction and dementia.

The 07/04/24 "FCS" conducted by facility staff was one year and 21 days after admission.

Review of R7's record lacked evidence that facility staff conducted an "FCS" on or before admission.

On 04/22/25 at approximately 01:07 PM Administrative Nurse B confirmed R7's record lacked evidence that designated staff conducted and "FCS" on or before admission.

On 04/23/25 at approximately 12:02 PM Administrative Staff A stated via email the facility did not have a specific policy regarding "Functional Capacity Screens" but they followed state regulations.

The administrator failed to ensure designated staff conducted an "FCS" for R3 and R7 on or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3080	Continued From page 18 before admission to the facility and failed to ensure a licensed nurse documented the assessment for R3 when his "FCS" indicated he required healthcare services.	S3080		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(2) The facility reported a census of 38 residents with three residents included in the sample. Based on interview and record review the administrator failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for Resident (R) 7 following significant changes when he admitted to and graduated from hospice and for R9 every 365 days. Findings included: - Record review for R7 revealed an admission date of 06/14/23 with diagnoses of cerebral	S3081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3081	Continued From page 19	S3081		

infarction and dementia.

The 07/04/24 "FCS" identified R7 was unable to perform management of treatments and medications; had long-term and memory/recall cognitive difficulties; and was at risk for impaired decision-making.

The 03/31/25 "NSA" identified facility staff administered medications per physician's orders, monitored and assisted as needed for cognitive difficulties, and he had a durable power of attorney (DPOA) for impaired decision-making. The "NSA" failed to describe services provided for management of treatments.

The 03/31/25 "NSA" identified a hospice provider

The 10/15/24 at 01:44 PM note documented hospice wrote comfort kit orders and faxed them.

On 04/22/25 at approximately 01:07 PM Administrative Nurse B stated R7 had been off and on hospice and confirmed an "NSA" had not been updated following the changes.

- Record review for R9 revealed an admission date of 05/10/23 with diagnoses of dementia and Alzheimer's Disease.

The 07/31/23 (most recent) "FCS" identified R9 was independent with activities of daily living (ADL's); had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was at risk for wandering.

The 04/17/25 "NSA" identified facility staff provided encouragement and redirection for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3081	Continued From page 20 cognitive difficulties and facility staff identified and prevented exit-seeking behavior with redirection. On 04/22/25 at approximately 02:26 PM Administrative Nurse B confirmed an "FCS" for R9 had not been completed every 365 days. On 04/23/25 at approximately 12:02 PM Administrative Staff A stated via email the facility did not have a specific policy regarding "Functional Capacity Screens", but they followed state regulations. The administrator failed to ensure designated staff completed an "FCS" for R7 following a significant change when he admitted to and graduated from hospice and for R9 every 365 days.	S3081		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 38 residents with three residents included in the sample and 11 focused reviews. Based on interview and record review the administrator failed to ensure designated facility staff ensured the "Functional	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3082	Continued From page 21	S3082		

Capacity Screen" (FCS) for Residents (R) 3 and R7 accurately reflected their functional capacity.

Findings included:

- Record review for R3 revealed an admission date of 05/20/24 with diagnoses of dementia and insomnia.

The 09/04/24 (107 days after admission) "FCS" documented the letter "I" next to transfers, walking/mobility, and eating.

The 10/17/24 (150 days after admission) "NSA" identified may require escort with a device for walking/mobility and may require assistance with eating.

On 04/21/25 at 04:29 PM Administrative Nurse B confirmed R3's "FCS" was not accurate.

- Record review for R7 revealed an admission date of 06/14/23 with diagnoses of cerebral infarction and dementia.

The 07/04/24 "FCS" identified R7 required supervision for bathing and was independent with dressing, toileting, transfers, and was continent of bladder. R7 was not at risk for falls.

The 03/31/25 "NSA" identified facility staff provided reminders and/or cueing for bathing, assistance with dressing, provided peri care for toileting, and encouraged R7 to sit down and use wheelchair, ensure fall mat in place, and provide more frequent checks to prevent injury from falls. The "NSA" failed to describe services provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3082	Continued From page 22 for transfers. On 04/22/25 at approximately 01:0 PM Licensed Nurse C B confirmed R7's "FCS" was not accurate. On 04/23/25 at approximately 12:02 PM Administrative Staff A stated via email the facility did not have a specific policy regarding "Functional Capacity Screens", but they followed state regulations. The administrator failed to ensure designated facility staff ensured the "FCS" for R3 and R7 accurately reflected their functional capacity.	S3082		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3085	Continued From page 23 This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1) The facility reported a census of 38 residents with thre residents included in the sample and 11 focused reviews. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreements" (NSA) for Resident (R) 3, R6, R7, and R8 described the services they received based on their "Functional Capacity Screens" (FCS). Findings included: - Record review for R3 revealed an admission date of 05/20/24 with diagnoses of dementia and insomnia. The 09/04/24 (107 days after admission) "FCS" identified R3 was unable to perform bathing, dressing, toilet, and management of medications and treatments. He was independent with transfers, walking/mobility, and eating. R3 was incontinent of bladder and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. He was rarely or never understandable and sometimes understood others during communication and was at risk for falls, impaired decision-making, wandering, and inappropriate behavior. The 10/17/24 (150 days after admission) "NSA" identified facility staff provided R3 assistance of two staff twice a week with bathing, assistance of two staff with dressing and toileting, and he was	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3085	Continued From page 24	S3085		

independent with transfers. R3 may require escort with a device for walking/mobility and may require assistance with eating. The facility provided R3 assistance of 2 staff for bladder incontinence and was on a toileting program. Staff monitored and assisted as needed for safety for cognitive difficulties and provided frequent checks to prevent injury from falls. Staff attempted to engage R3 in meaningful activities for wandering and provided behavior mapping and interventions for inappropriate behavior.

The 10/17/24 "NSA" failed to describe services provided R3 for management of medications, treatments, communication, and services provided by hospice.

On 04/21/25 at approximately 03:27 PM Administrative Nurse B confirmed R3's "NSA" failed to describe services provided for management of medications, treatments, communication and services provided by hospice.

- Record review for R6 revealed an admission date of 04/01/22 with a diagnosis of dementia.

The 12/22/24 "FCS" identified R6 required physical assistance with bathing; was unable to perform managment of medications and treatments; had long-term memory and memory/recall cognitive difficulties; and was at risk for impaired decision-making and wandering.

The 09/26/24 "NSA" identified facility staff provided R6 stand-by-assistance with bathing; administered medications per physician's orders; she had a durable power of attorney (DPOA) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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
S3085	Continued From page 25	S3085		

impaired decision-making; and facility staff redirected and engaged her in activities for wandering behavior.

The 09/26/24 "NSA" failed to describe services provided R6 for managment of treatments and cognition.

On 04/22/25 at approximately 01:37 PM Administrative Nurse B confirmed services provided for management of treatments and cognition were not described on R6's "NSA."

- Record review for R7 revealed an admission date of 06/14/23 with diagnoses of cerebral infarction and dementia.

The 0704/24 "FCS" identified R7 was unable to perform management of treatments and medications; had long-term and memory/recall cognitive difficulties; and was at risk for impaired decision-making.

The 03/31/25 "NSA" identified facility staff administered medications per physician's orders, monitored and assisted as needed for cognitive difficulties, and he had a durable power of attorney (DPOA) for impaired decision-making.

The 03/31/25 "NSA" failed to describe services provided for management of treatments and services provided by hospice.

On 04/22/25 at approximately 01:07 PM Administrative Nurse B confirmed services provided for management of treatments and services provided by hospice were not described on R7's "NSA."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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
S3085	Continued From page 26	S3085		

- Record review for R8 revealed an admission date of 10/03/23 with a diagnosis of dementia.

The 04/02/24 "FCS" identified R8 was unable to perform bathing, dressing, toileting, and management of medications and treatments; required physical assistance with transfers and walking/mobility; was incontinent of urine; had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties; and was at risk for falls and impaired decision-making.

The 04/01/24 "NSA" identified facility staff provided R8 assistance of two staff with bathing, toileting, and transfers with a mechanical lift; assistance of one staff with dressing, propelling his wheelchair for walking/mobility, and bladder incontinence; assistance of one qualified staff for medications and treatments; and he had a durable power of attorney (DPOA) for impaired decision-making.

The "NSA" failed to describe service provided for cognition and falls.

On 04/22/25 at approximately 02:08 PM Administrative Nurse B confirmed services provided for cognition and falls were not described on R8's "NSA."

On 04/21/25 at 03:46 PM Administrative Nurse B stated the facility's form titled "Service Plan" was the "NSA."

On 04/23/25 at approximately 12:02 PM Administrative Staff A stated via email the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3085	Continued From page 27 did not have a specific policy regarding "NSAs" but they followed state regulations. The administrator failed to ensure the "NSA's" for R3, R6, R7, and R8 described the services they received based on their "FCS's."	S3085		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(c) The facility reported a census of 38 residents with three residents included in the sample and 11 focused reviews. Based on interview and record review the administrator failed to ensure the development of an initial "Negotiated Service Agreement" (NSA) at admission for Residents (R) 3. Findings included: - Record review for R3 revealed an admission date of 05/20/24 with diagnoses of dementia and insomnia. The 09/04/24 (107 days after admission) "FCS" identified R3 was unable to perform bathing,	S3090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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
S3090	Continued From page 28	S3090		

dressing, toilet, and management of medications and treatments. He was independent with transfers, walking/mobility, and eating. R3 was incontinent of bladder and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. He was rarely or never understandable and sometimes understood others during communication and was at risk for falls, impaired decision-making, wandering, and inappropriate behavior.

The 10/17/24 (150 days after admission) "NSA" identified facility staff provided R3 assistance of two staff twice a week with bathing, assistance of two staff with dressing and toileting, and he was independent with transfers. R3 may require escort with a device for walking/mobility and may require assistance with eating. The facility provided R3 assistance of 2 staff for bladder incontinence and was on a toileting program. Staff monitored and assisted as needed for safety for cognitive difficulties and provided frequent checks to prevent injury from falls. Staff attempted to engage R3 in meaningful activities for wandering and provided behavior mapping and interventions for inappropriate behavior. The "NSA" failed to describe services provided for management of medications, treatments, and communication.

R3's record lacked evidence of documentation designated staff ensured the development of a "NSA" at admission on 05/20/24.

On 04/21/25 at 03:46 PM Administrative Nurse B stated the facility's form titled "Service Plan" was the "NSA."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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
S3090	Continued From page 29 On 04/22/25 at approximately 10:52 AM Administrative Nurse B confirmed R3's lacked evidence of documentation designated staff ensured the development of an "NSA" at admission. On 04/23/25 at approximately 12:02 PM Administrative Staff A stated via email the facility did not have a specific policy regarding "Negotiated Service Agreement", but they followed state regulations. The administrator failed to ensure the development of an initial "NSA" at admission for R3.	S3090		
S3101 SS=D	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 38 residents with three residents included in the sample and 11 focused reviews. Based on interview and record review the administrator failed to ensure designated staff ensured each individual involved in the development of the "Negotiated	S3101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

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S3101	Continued From page 30	S3101		

Service Agreement" (NSA) signed the agreement for Resident (R)7.

Findings included:

- Record review for R7 revealed an admission date of 06/14/23 with diagnoses of cerebral infarction and dementia.

The 07/04/24 "Functional Capacity Screen" (FCS) identified R7 was unable to perform management of treatments and medications; had long-term and memory/recall cognitive difficulties; and was at risk for impaired decision-making.

The 03/31/25 "NSA" identified facility staff administered medications per physician's orders, monitored and assisted as needed for cognitive difficulties, and he had a durable power of attorney (DPOA) for impaired decision-making. The "NSA" failed to describe services provided for management of treatments.

The 03/31/24 "NSA" lacked signature of R7's legal representative.

On 04/21/25 at 03:46 PM Administrative Nurse B stated the facility's form titled "Service Plan" was the "NSA."

On 04/22/25 at approximately 01:07 PM Administrative Nurse B confirmed R7's "NSA" lacked a signature of his legal representative.

On 04/23/25 at approximately 12:02 PM Administrative Staff A stated via email the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

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S3101	Continued From page 31 did not have a specific policy regarding "Negotiated Service Agreements" but they followed state regulations. The administrator failed to ensure designated staff ensured each individual involved in the development of the "NSA" signed the agreement for R7.	S3101		
S3102 SS=D	26-41-202 (i) Negotiated Service Agreement Service Received (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) The facility reported a census of 38 residents. Based on observation, interview, and record review the administrator failed to ensure Resident (R) 3 received the services as described in his "Negotiated Service Agreement" (NSA) for wandering. Findings included: - Record review for R3 revealed an admission date of 05/20/24 with diagnoses of dementia and insomnia. The 09/04/24 (107 days after admission) "FCS" identified R3 was at risk for wandering.	S3102		

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

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S3102	Continued From page 32	S3102		

The 10/17/24 (150 days after admission) "NSA" identified facility staff attempted to engage R3 in meaningful activities for wandering.

On 04/21/25 at 03:46 PM Administrative Nurse B stated the facility's form titled "Service Plan" was the "NSA."

Observation on 04/21/25 at approximately 04:12 PM revealed R3 ambulated in common area and stopped at the door to the conference room. A receptionist sat at the front desk. Observed no other staff were present monitoring or attempting to engage R3 in meaningful activities for wandering according to his "NSA."

On 04/21/25 at approximately 04:12 PM Administrative Staff stated "That's what he (R3) does. He walks around and checks all the doors."

On 04/22/25 at 11:23 AM Administrative Nurse B stated she expected direct-care staff to recognize a resident was exit-seeking if one became restless, tried to open doors, or verbalized they wanted to leave or go home.

On 12/13/22 at 08:39 AM Administrative Staff A stated the "NSA" and "HCP" were combined in one document.

The facility's 12/19/24 "Elopement" policy documented the facility would identify residents who were at risk of elopement and strive to prevent harm.

The administrator failed to ensure R3 received the services as described in his "NSA" for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

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S3102	Continued From page 33 wandering.	S3102		
S3250 SS=E	26-41-105 (a) Resident Records a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: KAR 26-41-105(a)(1) The facility reported a census of 38 residents with three residents included in the sample and 11 closed record reviews. Based on record review and interview the administrator failed to ensure maintenance of records for Residents (R) 12, R13, R14, and R15 for at least five years after their discharge. Findings included: - Record review for R12 revealed an admission	S3250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3250	Continued From page 34	S3250		

date of 08/29/23 with a diagnosis of dementia.

The 04/20/24 nursing "Progress Note" documented R12 time of death.

Review of R12's medical record revealed lack of functional capacity screens.

- Record review for R13 revealed an admission date of 04/01/22 with a diagnosis of dementia.

The 12/12/23 nursing "Progress Note" documented R13 lacked vital signs with respirations of zero.

Review of R13's medical record revealed lack of functional capacity screens.

- Record review for R14 revealed an admission date of 06/23/23 with a diagnosis of Alzheimer's Disease.

The 08/16/23 nursing "Progress Note" documented R14's family member had questions and concerns regarding R14 moving out of the facility.

Review of R14's medical record revealed lack of functional capacity screens.

- Record review for R15 revealed an admission date of 01/15/24 with a diagnosis of Alzheimer's Disease.

The 12/29/24 nursing "Progress Note" documented R15's time of death.

Review of R15's medical record revealed lack of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3250	Continued From page 35 functional capacity screens. On 04/22/25 at 11:34 AM Administrative Staff A stated all the records retrieved from storage were all the storage company provided. Confirmed were still missing records for R12, R13, R14, and R15. The operator failed to maintain 12, R13, R14, and R15 for at least five years after their discharge.	S3250		
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) The facility reported a census of 38 residents with three residents included in the sample and 11 focused reviews. Based on interview and record review the administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the date, time, action taken, and results of the action for Resident (R) 3 and R6. Findings included:	S3261		

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3261	Continued From page 36 - Record review for R3 revealed an admission date of 05/20/24 with diagnoses of dementia and insomnia. The 09/04/24 (107 days after admission) "FCS" identified R3 was unable to perform bathing, dressing, toilet, and management of medications and treatments. He was independent with transfers, walking/mobility, and eating. R3 was incontinent of bladder and had short-term and long-term memory, memory/recall, and decision-making cognitive difficulties. He was rarely or never understandable and sometimes understood others during communication and was at risk for falls, impaired decision-making, wandering, and inappropriate behavior. The 10/17/24 (150 days after admission) "NSA" identified facility staff provided R3 assistance of two staff twice a week with bathing, assistance of two staff with dressing and toileting, and he was independent with transfers. R3 may require escort with a device for walking/mobility and may require assistance with eating. The facility provided R3 assistance of 2 staff for bladder incontinence and was on a toileting program. Staff monitored and assisted as needed for safety for cognitive difficulties and provided frequent checks to prevent injury from falls. Staff attempted to engage R3 in meaningful activities for wandering and provided behavior mapping and interventions for inappropriate behavior. The "NSA" failed to describe services provided for management of medications, treatments, and communication. The 06/11/24 at 06:12 PM nursing "Progress	S3261		

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	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3261	Continued From page 37	S3261		

Note" documented R3 had redness to groin area and one foot dragged while he walked and "will continue to monitor."

Review of nursing "Progress Notes" from 06/11/24 to 04/08/25 revealed licensed staff failed to document follow up monitoring if R3's symptoms worsened or improved, action taken and results of the action.

On 04/22/25 at 12:10 PM Administrative Nurse confirmed R3's record lacked evidence of documentation licensed staff monitored groin area redness and if his foot dragged.

The 06/15/24 at 09:50 PM nursing "Progress Note" documented R3 on fall follow monitoring.

Review of nursing "Progress Notes" from 06/01/24 (move-in date) to 06/15/24 revealed licensed staff failed to document the fall incident including the date, time of occurrence, action taken, and results of the action.

On 04/22/25 at 11:32 PM Administrative Nurse B stated R3 fell on 06/13/25 and confirmed licensed staff failed to document the fall in nursing "Progress Notes."

- Record review for R6 revealed an admission date of 04/01/22 with a diagnosis of dementia.

The 12/22/24 "FCS" identified R6 required physical assistance with bathing; was unable to perform management of medications and treatments; had long-term memory and memory/recall cognitive difficulties; and was at risk for impaired decision-making and wandering.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3261	Continued From page 38	S3261		

The 09/26/24 "NSA" identified facility staff provided R6 stand-by-assistance with bathing; administered medications per physician's orders; she had a durable power of attorney (DPOA) for impaired decision-making; and facility staff redirected and engaged her in activities for wandering behavior. The "NSA" failed to describe services provided for management of treatments and cognition.

10/24/24 at 02:03 AM nursing "Progress Note" documented R6 was restless, exit seeking, and yelled at staff and other residents. Staff attempted unsuccessfully to redirect her. Licensed Nurse M administered an as needed calming medication and walked out of the common area. Licensed Nurse M then heard R6 and R7 yelling at each other and turned around. Licensed Nurse M observe R7 pushed R6 who fell on the floor and hit her head. R6 sustained a large bump on the right side of her forehead and went to the hospital for further evaluation.

Review of nursing "Progress Notes" revealed licensed staff failed to document the date and time when R6 first became restless, exhibited exit-seeking behavior, and yelled at staff and other residents including actions taken and results of the actions before R6 became involved in an altercation with another resident which resulted in her going to the hospital for evaluation for a head injury.

On 04/22/25 at approximately 01:37 PM Administrative Nurse B stated R6 typically began exhibiting aggressive behaviors around dinner time about 04:00 PM to 05:00 PM and confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3261	Continued From page 39 licensed staff failed to document the date and time when R6 first became restless, exhibited exit-seeking behavior, and yelled at staff and other residents including actions taken and results of the actions before R6 became involved in an altercation with another resident. The 01/10/24 facility's "Charting Guidelines and Approved Abbreviations" policy documented a health record documented interventions, services, and care provided according to regulatory and professional standards. The administrator failed to ensure licensed staff documented all incidents, symptoms, indications of illness or injury including the date, time, action taken, and results of the action for Resident (R) 3 and R6.	S3261		
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.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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
S3280	Continued From page 40	S3280		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-104(d)(3)(4)

The facility reported a census of 38 residents. Based on interview and record review the administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents and staff every quarter and conducted an evacuation drill with residents to a secured location at least annually.

Findings included:

- Review of the facility's emergency management plan from 10/01/23 to 04/08/25 revealed designated staff failed to conduct quarterly reviews of the plan and evacuation drills at least annually.

On 04/14/25 at approximately 11:10 AM Maintenance Staff D confirmed facility records lacked evidence of documentation designated staff provided reviews of the facility's emergency management plan with staff and residents every quarter and conducted an evacuation drill with residents to a secured location at least annually.

On 04/23/25 at approximately 12:02 PM Administrative Staff A stated via email the facility did not have a specific policy regarding quarterly reviews of the emergency management plan and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3280	Continued From page 41 annual evacuation drills, but they followed state regulations. The administrator failed to provide evidence of documentation designated staff provided reviews of the facility's emergency management plan with residents and staff every quarter and conducted an evacuation drill with residents to a secured location at least annually.	S3280		
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 by: KAR 26-41-207(c) The facility reported a census of 37 residents with three residents included in the sample. Based on interview and record review, the administrator failed to ensure the facility	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3310	Continued From page 42	S3310		

remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105 for Resident (R) 3, R7, and five of five sampled staff.

Findings included:

- Review of R3's record revealed an admission date of 05/20/24 with a diagnosis of dementia.

The 06/11/24 at 06:12 PM nursing "Progress Note" documented R3 returned from a hospital stay. His record lacked evidence of documentation a TB symptom screen questionnaire was completed upon return from his hospitalization.

The 09/04/24 at 02:04 PM nursing "Progress Note" documented R3 returned from a hospital stay. His record lacked evidence of documentation a TB symptom screen questionnaire was completed upon return from his hospitalization.

On 04/21/25 at 03:41 PM Administrative Nurse B confirmed R3's record lacked evidence of documentation a TB symptom screen questionnaire was completed upon return his hospitalization.

- Review of R7 revealed an admission date of 06/14/23 with diagnoses of cerebral infarction and dementia.

The 07/23/24 at 02:28 PM nursing "Progress Note" documented R7 returned from a hospital stay. His record lacked evidence of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	12701 PFLUMM ROAD OVERLAND PARK, KS 66213

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S3310	Continued From page 43	S3310		

documentation a TB symptom screen questionnaire was completed upon return from his hospitalization.

On 04/22/25 at 01:07 PM Administrative Nurse B confirmed R7's record lacked evidence of documentation a TB symptom screen questionnaire was completed upon return from his hospitalization.

- Review of Certified Medication Aide (CMA) E's employee record revealed a hire date of 03/10/25. Her record lacked evidence of documentation she completed a two-step TB skin test within seven days of hire.

Review of Licensed Nurse F's employee record revealed a hire date of 06/06/24. The 05/30/25 TB blood test results were "borderline" with recommendations to re-test. Licensed Nurse F's record lacked evidence of documentation he completed a TB blood re-test and a TB symptom screen questionnaire within seven days of hire.

Review of Certified Nurse Aide (CNA) G's employee record revealed a hire date of 07/14/23. Her record lacked evidence of documentation she completed a TB symptom screen questionnaire. The 07/07/23 first step of a two-step TB skin test lacked evidence of documentation of results.

Review of CNA H's employee record revealed a hire date of 01/20/25. Her record lacked evidence of documentation she completed a TB symptom screen questionnaire and two-step TB skin test within seven days of hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046095	A. BUILDING: _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO OVERLAND PARK	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
S3310	Continued From page 44 Review of Licensed Nurse I's employee record revealed a hire date of 12/23/24. Her record lacked evidence of documentation she completed a TB symptom screen questionnaire within seven days of hire. The 12/10/24 first step of a two-step TB skin test was read on 12/12/24 with a negative result. Licensed Nurse I's record lacked evidence of documentation she completed the second step of the test. The 03/04/24 facility's "Administration and Reading of TB Skin Test by Charge Nurse" policy documented testing would be provided to ensure compliance as well as to detect and prevent the spread of TB within the community. The policy did not address TB symptom screen questionnaires. On 04/14/25 at approximately 03:35 PM Administrative Staff C confirmed CMA E, CNA G and CNA H and Licensed Nurses F and I's records lacked evidence of documentation they completed TB screening per the department's guidelines. The administrator failed to ensure the facility remained in compliance with the department's TB guidelines for adult care homes for R3, R7, and five of five sampled staff.	S3310		