STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175180	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Park Post Acute	5211 W 103rd Street Overland Park, KS 66207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 126 residents. The sample included four residents with one reviewed for accommodation of needs. Based on observation, record review, and interview, the facility failed to provide necessary foot care and services for Resident (R) 1.Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of pain in right knee, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), difficulty in walking, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The admission Minimum Data Set (MDS) dated 12/02/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. The Quarterly MDS dated 08/22/25, documented R1 had a BIMS score of eight, which indicated moderate cognitive impairment. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/07/24, lacked an analysis of findings. R1's 01/15/26 Care Plan documented R1 had actual risk for activities of daily living (ADL)/mobility decline and required assistance related to pain in the right knee, muscle weakness, and difficulty in walking. The Care Plan documented the following interventions:01/15/26- R1 required one staff set-up assistance with ambulation.01/15/26- R1 required one staff set-up assistance with transfers. R1's 01/15/26 Care Plan documented R1 had a diagnosis of diabetes. The Care Plan documented the following interventions:01/15/26- Staff encouraged activity and exercise as tolerated. R1's EMR revealed the following: A Nurse's Note on 10/29/25 at 02:13 PM documented the facility left a voicemail for the diabetic shoe provider and waited for a return call. A Podiatry Order Form, dated 11/03/25, documented an order for diabetic shoes and three pairs of heat molded diabetic insoles. A Nurse's Note on 11/04/25 at 11:30 AM, documented the diabetic shoe provider answered the phone and advised the facility they needed multiple documents. The facility nurse stated the facility sent the documents many, many times but would send the documents again. A Nurse's Note on 11/05/25 at 11:26 AM, documented the facility sent documents to the diabetic shoe provider again and waited for a return call to schedule an appointment. A Nurse's Note on 11/14/25 at 01:52 PM, documented the facility left another voicemail to set-up an appointment for R1's shoes and waited for a return call.R1's EMR lacked evidence the facility followed up with the diabetic shoe provider after 11/14/25. On 02/02/26 at 12:54 PM, R1 sat in her recliner in her room. She stated she still needed diabetic shoes. On 02/02/26 at 02:05 PM, R1 laid on her right side in her bed. She did not respond to knocking and appeared to be sleeping. R1's right heel had a rough, calloused appearance. On 02/02/26 at 12:57 PM, Licensed Nurse (LN) G stated the facility had been working on getting R1's diabetic shoes for a year and a half. She stated the facility received a form from podiatry for diabetic shoes and form insoles and the facility faxed the diabetic shoe provider back and forth, but they had not responded. On 02/02/26 at 01:40 PM, Administrative Nurse D stated she believed the facility was going to send R1 to the diabetic shoe provider to get her fitted for diabetic shoes, but Administrative Nurse D was unsure (continued on next page)

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 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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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if R1 went. She stated she expected the nurse to do a weekly follow-up to figure out what was going on with the diabetic shoe provider appointment. Administrative Nurse D stated it sometimes took time to get a resident into the diabetic shoe provider but R1 should have at least gotten an appointment date set by now. She stated the facility should have followed up with the diabetic shoe provider by now. On 02/02/26 at 02:20 PM, Administrative Nurse D stated she found out more information about the diabetic shoe provider. She stated R1 had an appointment with the diabetic shoe provider on 08/13/25 and did not show up. She stated R1 had not wanted to reschedule the appointment but at the time, R1 had gone through psychosis (any major mental disorder characterized by a gross impairment in reality perception) and had an involuntary placement in a facility around that time. Administrative Nurse D stated the diabetic shoe provider stated they did not have any other information about any referrals after that and only had the one note from August 2025. The facility did not provide a policy on durable medical equipment or accommodation of needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 126. The sample included four residents with one sample for respiratory services. Based on observation, record review, and interviews, the facility failed to obtain and provide a physician-ordered continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) machine for Resident (R) 1.Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The admission Minimum Data Set (MDS) dated 12/02/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. The Quarterly MDS dated 08/22/25, documented R1 had a BIMS score of eight, which indicated moderate cognitive impairment. The Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA) dated 12/07/24, lacked an analysis of findings. R1's 01/15/26 Care Plan documented R1 required the use of continuous oxygen at two liters (L) related to COPD. The Care Plan documented the following interventions:01/15/26 - Staff changed R1's humidification and oxygen tubing as indicated.01/15/26 - Staff educated R1 on the importance of keeping oxygen on and at the prescribed setting.01/15/26 - Staff observed oxygen precautions.The Care Plan did not address her order for a CPAP. R1's EMR revealed the following: An order with a start date of 08/08/25 for CPAP setting, which instructed staff to set the CPAP per home settings at bedtime for CPAP. An order with a start date of 08/08/25 instructed staff to replace R1's distilled water in the humidifier prior to CPAP/BiPAP (device that helps you breathe by delivering air through a mask on your face) use at bedtime for CPAP/BiPAP. Review of R1's Treatment Administration Record (TAR) for 08/08/25 to 01/31/26 revealed the following documentation for the order of CPAP setting: per home settings at bedtime for CPAP:Staff administered- 110 out of 177 scheduled administrationsR1 refused- 37 out of 177 scheduled administrationsBlank documentation- 24 out of 177 scheduled administrationsHold/See Nurses Notes- two out of 177 scheduled administrationsOther/See Nurses Notes- three out of 177 scheduled administrationsAbsent from home- one out of 177 scheduled administrations Review of R1's TAR for 08/08/25 o 01/31/26 revealed the following documentation for the order to replace R1's distilled water in the humidifier prior to CPAP/BiPAP use at bedtime for CPAP/BiPAP:Staff administered- 111 out of 177 scheduled administrationsR1 refused- 35 out of 177 scheduled administrationsBlank documentation- 24 out of 177 scheduled administrationsHold/See Nurses Notes- four out of 177 scheduled administrationsOther/See Nurses Notes- two out of 177 scheduled administrationsAbsent from home- one out of 177 scheduled administrations R1's EMR revealed the following: An eMAR (electronic Medication Administration Record)- Medication Administration Note on 10/29/25 at 01:45 AM, documented R1 did not want to use the CPAP. R1 did not have her equipment in the facility. An eMAR- Medication Administration Note on 11/08/25 at 01:09 AM, documented R1 was non-compliant with use of CPAP. An eMAR- Medication Administration Note on 11/14/25 at 02:55 AM, documented R1 no longer wore the CPAP. An eMAR- Medication Administration Note on 12/15/25 at 10:30 PM, documented R1 verbalized she did not have a CPAP, and she did not use one. An eMAR- Medication Administration Note on 12/23/25 at 11:35 PM, documented R1 verbalized she did not have a CPAP, and the facility never got her a CPAP. On 02/02/26 at 12:54 PM, R1 sat in her recliner in her room. There was no CPAP visible in R1's room. R1 stated she does not have a CPAP machine because she never received one, but she does wear oxygen at night. On 02/02/26 at 12:57 PM, Licensed Nurse (LN) G stated R1 never had a CPAP in the facility, but she admitted to the facility with an order for a CPAP. LN G stated she marked (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's CPAP order as refused on the TAR. When asked how R1 could refuse something she never had, LN G stated she used refused for R1 not having a CPAP too. LN G stated that most residents who were admitted to the facility with a CPAP order brought a CPAP machine with them. She stated R1 had not voiced any concerns to her about having a CPAP. On 02/02/26 at 01:40 PM, Administrative Nurse D stated she did not know if R1 had a CPAP. She stated if a resident admitted to the facility with an order for a CPAP, they usually came with the CPAP machine, and the facility did not normally provide one. Administrative Nurse D stated if they did not have a machine, the facility worked with the physician to get approval and to set up a sleep study. She stated R1's CPAP order should have been discontinued if she did not have a CPAP. She stated she expected the nurse to let the physician know to get an order to hold or discontinue the order. The facility's CPAP/BiPAP Support policy, revised March 2015, directed the facility review the physician's order to determine the oxygen concentration and flow, and the pressure for the machine. The policy did not address providing a CPAP machine.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 126. The sample included four residents with one sampled for pharmacy services. Based on observation, record review, and interviews, the facility failed to provide physician ordered Mounjaro (medication used to manage type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin)) to Resident (R) 1. Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of pain in right knee, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), difficulty in walking, and diabetes mellitus. The admission Minimum Data Set (MDS) dated 12/02/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. The Quarterly MDS dated 08/22/25, documented R1 had a BIMS score of eight, which indicated moderate cognitive impairment. The Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA) dated 12/07/24, lacked an analysis of findings. R1's 01/15/26 Care Plan documented R1 had a diagnosis of diabetes. The Care Plan documented the following interventions:01/15/26- Staff administered medications as ordered.01/15/26- Staff encouraged activity and exercise as tolerated. R1's EMR revealed an order with a start date of 08/11/25 for Mounjaro 2.5 milligrams (mg)/0.5 milliliters (mL), inject 0.5 mL in the morning every Monday for diabetes. Review of R1's Treatment Administration Record (TAR) for 09/01/25 through 01/31/26, revealed the following documentation for Mounjaro 0.5 mL:Staff administered- two out of 22 scheduled administrations.Blank documentation- two out of 22 scheduled administrations. Other/See Nurses Notes- 18 out of 22 scheduled administrations. R1's EMR revealed the following: An eMAR (electronic Medication Administration Record)- Medication Administration Note on 09/15/25 at 09:56 AM documented Mounjaro was unavailable, and the facility waited for delivery. An eMAR- Medication Administration Note on 10/13/25 at 10:25 AM, documented the facility waited for the delivery of Mounjaro. An eMAR- Medication Administration Note on 10/20/25 at 11:59 AM, documented Mounjaro was unavailable, and the facility contacted the pharmacy and reordered Mounjaro. An eMAR- Medication Administration Note on 10/27/25 at 09:56 AM, documented Mounjaro was on order. An eMAR- Medication Administration Note on 11/03/25 at 10:38 AM, documented the facility awaited clarification on Mounjaro. The note did not address what the clarification was in regard to. An eMAR- Medication Administration Note on 11/10/25 at 11:00 AM, documented the facility notified the nurse practitioner (NP). The note did not address what the facility notified the NP about. An eMAR- Medication Administration Note on 12/15/25 at 09:20 AM, documented Mounjaro was unavailable. A Physician Progress Note (Narrative) on 12/17/25 at 10:54 AM, documented R1's fasting blood sugar reading was over 500 milligrams per deciliter (dL) that morning. Nursing staff denied R1 had any new problems. The provider increased R1's Lantus (insulin- a hormone that lowers the level of glucose in the blood) order to 100 units at bedtime and ordered an endocrinology (the study of endocrine glands and hormones) appointment for R1. The provider instructed the facility to continue R1's current medications and orders. The note did not address R1's Mounjaro. An eMAR- Medication Administration Note on 12/22/25 at 05:29 AM, documented Mounjaro was unavailable. An eMAR- Medication Administration Note on 12/29/25 at 09:38 AM, documented Mounjaro was unavailable. An eMAR- Medication Administration Note on 01/05/26 at 09:38 AM, documented Mounjaro was unavailable. An eMAR- Medication Administration Note on 01/12/26 at 09:36 AM, documented Mounjaro was unavailable. An eMAR- Medication Administration Note on 01/19/26 at 11:09 AM, documented Mounjaro was unavailable. An eMAR- Medication Administration Note on 01/26/26 at 09:45 AM, documented (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mounjaro was unavailable. A Nurse's Note on 02/02/26 at 12:36 PM, documented the pharmacy advised Licensed Nurse (LN) G that R1's insurance would pay for Mounjaro at that time, then they would need a prior authorization for the next time. The pharmacy ordered R1's Mounjaro and would send it to the facility. A Nurse's Note on 02/02/26 at 01:43 PM, documented LN G notified Consultant GG of the above note on 02/02/26. Consultant GG advised LN G to discontinue R1's order. On 02/02/26 at 12:54 PM, R1 sat in her recliner in her room. She stated she had not received her Mounjaro injections, but she wanted to be on it. On 02/02/26 at 12:57 PM, LN G stated she had just called the pharmacy about R1's Mounjaro. She stated the Mounjaro needed a prior authorization to be paid for by her pharmacy. She stated the pharmacy approved for R1's Mounjaro to be paid this time but she would need a prior authorization next time. LN G stated if a resident needed a prior authorization, she put them into the provider's folder to be completed. She stated she documented in the resident's EMR if a resident needed a prior authorization. LN G stated if a resident had not received a medication, she called the provider and told them the reason why that resident had not received the medication, and asked what the provider wanted to do. On 02/02/26 at 01:40 PM, Administrative Nurse D stated she had not received any reports about R1 not receiving her Mounjaro. She stated she expected staff to bring it up to her or with the physician to get a prior authorization. She stated the pharmacy sent prior authorization requests electronically and she usually received a copy, but she had not seen one for R1's Mounjaro. Administrative Nurse D stated she expected staff to notify her and the physician after one missed dose of a medication and to document on it. On 02/02/26 at 02:06 PM, LN G stated she called Consultant GG and told him the pharmacy could send the Mounjaro that time, then they needed a prior authorization. She stated Consultant GG said to discontinue the order. LN G stated she did not talk to R1 about the order to see if she wanted to be on it prior to calling Consultant GG. The facility's Pharmacy Services Overview policy, revised April 2019, directed the residents had a sufficient supply of their prescribed medications and receive their medications in a timely manner.