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	05/26/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent medication errors when they failed to reconcile pain medication orders from the hospital on readmission for Resident (R) 1. Findings included:- R1 admitted to the facility on [DATE], discharged to the hospital on [DATE], readmitted to the facility on [DATE], transferred to the hospital on [DATE], returned to the facility on [DATE], and discharged to the hospital on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of low back pain, secondary malignant neoplasm (tumor) of bone, malignant neoplasm of prostate, and type 2 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 03/24/26 documented R1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R1 received scheduled and as needed (PRN) pain medication. R1 complained of occasional pain with a highest pain rating of four out of 10 in the last five days. The Pain Care Area Assessment (CAA) dated 03/25/26 documented R1 complained of chronic lower back pain. R1's 04/10/26 Care Plan documented R1 had chronic pain related to cancer. The plan documented the following interventions:04/10/26- Staff administered analgesic medications per orders and half an hour before treatments or care.04/10/26- Staff anticipated R1's need for pain relief and responded immediately to any complaint of pain.04/10/26- Staff evaluated the effectiveness of pain interventions, reviewed compliance, alleviation of symptoms, dosing schedules, R1's satisfaction with results, impact on functional abilities, and impact on cognition.04/10/26- Staff monitored/documented for probable cause of each pain episode and removed or limited the cause where possible.04/10/26- Staff monitored/documented for side effects of pain medication.04/10/26- Staff notified R1's physician if his interventions were unsuccessful or if his current complaint of pain was a significant change from R1's past experience of pain. R1's EMR revealed the following: An order with a start date of 04/07/26 and a discontinued date of 05/04/26 for oxycodone hydrochloride (HCl) (opioid pain medication) 30 milligrams (mg) every 12 hours for moderate to severe pain. An order with a start date of 04/07/26 and a discontinued date of 05/04/26 for hydromorphone HCl (opioid pain medication), four mg every three hours as needed for excessive pain related to secondary malignant neoplasm of bone and malignant neoplasm of prostate. An order with a start date of 04/07/26 and a discontinued date of 05/04/26 for pregabalin (medication used to treat seizures and nerve pain) 250 mg two times a day for diabetic complications. An order with a start date of 05/04/26 for hydromorphone HCl, six mg every three hours as needed for excessive, cancer-related pain. Hospital paperwork, printed on 05/04/26 at 09:36 AM, documented R1's medication list had orders for R1 to start. The orders to start included hydromorphone six mg every six hours as needed for excessive cancer related pain, oxycodone 20 mg every eight hours for severe chronic pain requiring long-term opioid treatment, and pregabalin 300 mg twice daily for diabetic complication causing injury to some body nerves. An order with a start date of 05/04/26 and a discontinued date of 05/08/26 for oxycodone 30 mg every eight hours as needed for chronic pain. An admission Summary note on 05/04/26 at 04:26 PM documented R1 arrived at the facility at 02:20 PM and denied pain when asked. The nurse encouraged R1 to request a pain pill when needed. A Behavior Note on 05/04/26 at 05:13 PM documented R1 asked the (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse where his medications were, and the nurse educated R1 that his orders were in place and should arrive soon. R1 yelled at the nurse that he had withdrawals but refused to answer what symptoms he had when asked. An eMAR [electronic medication administration record]- Medication Administration Note on 05/04/26 at 06:58 PM documented R1 received hydromorphone HCl six mg for pain rated at a nine out of 10. A Nurse's Note on 05/05/26 at 04:30 AM documented R1 requested to be sent to the hospital due to acute pain in his legs, back, and chest with chills and sweat and withdrawal from hydromorphone. A Nurse's Note on 05/05/26 at 08:07 AM documented the emergency room (ER) called for report and asked why R1 was in the ER. Staff informed the ER of R1's concerns of uncontrolled pain and explained to the ER provider what medications R1 received over the night and that he had medications readily available. The nurse stated to the ER provider that R1 immediately claimed withdrawal when he admitted but he showed no signs or symptoms and he was not cooperative with staff to receive proper help. A Nurse's Note on 05/05/26 at 09:05 AM documented the hospital called to give report that they were sending R1 back with a scheduled order for Dilaudid (hydromorphone) so R1 could not argue about when he needed it for better pain control. A hospital After Visit Summary printed 05/05/26 at 09:06 AM documented R1's medications included hydromorphone six mg every three hours as needed for excessive cancer related pain, oxycodone 20 mg every eight hours for severe chronic pain requiring long-term opioid treatment, and pregabalin 300 mg twice daily for diabetic complication causing injury in some body nerves. A Nurse's Note on 05/05/26 at 09:28 AM documented the hospital called back to report they gave R1 baclofen (muscle relaxer medication), Lyrica (pregabalin), and Dilaudid for his back pain, and R1 stated he did feel relief. The nurse asked the ER if they were sending the orders, as the previous report said he was supposed to start scheduled Dilaudid. The ER nurse reported they could not do that as they just evaluated R1. The ER nurse asked what pharmacy to send the scheduled order to, and the nurse asked why the ER could not send the order to the facility, and the ER stated they just do not. The nurse notified Consultant GG of that information and asked how he wanted to proceed. Consultant GG instructed the nurse to evaluate R1 when he arrived, then call him. A Nurse's Note on 05/05/26 at 11:03 AM documented R1 arrived via ambulance. R1 asked for something for pain, and staff advised him that the ER report said he received pain medication prior to the transfer. R1's EMR lacked evidence the facility reconciled R1's medication list on 05/04/26 or 05/05/26 with hospital orders for scheduled oxycodone HCl and pregabalin. An order with a start date of 05/08/26 for oxycodone HCl extended release 20 mg three times a day for pain management. An order with a start date of 05/08/26 for pregabalin 300 mg two times a day related to secondary malignant neoplasm of bone and sciatica (pain that travels down the sciatic nerve). Review of R1's MAR for 05/04/26 to 05/09/26 revealed R1 received oxycodone 30 mg as needed on 05/04/26 at 08:48 PM; 05/07/26 at 03:24 AM, 02:11 PM, and 11:17 PM; and on 05/08/26 at 12:30 PM. R1 did not receive his scheduled oxycodone HCl 20 mg every eight hours as prescribed by the hospital from [DATE] on admission to 05/08/26 at 10:00 PM when he received his first dose. R1 did not receive his scheduled pregabalin 300 mg twice daily as prescribed by the hospital from [DATE] on admission to 05/08/26 at 05:00 PM when he received his first dose. The MAR documented the following pain levels out of 10: 05/04/26 Night- 10; 05/05/26 Day- 10, 05/05/26 Night- 10; 05/06/26 Day- seven, 05/06/26 Night- seven; 05/07/26 Day- eight, 05/07/26 Night- eight; 05/08/26 Day- 10, 05/08/26 Night- eight. R1's EMR lacked documentation as to why the oxycodone HCl 20 mg every eight hours and pregabalin 300 mg twice daily orders were not reconciled or started as ordered by the hospital. On 05/26/26 at 02:38 PM, Licensed Nurse (LN) G stated she remembered when R1 came back from the hospital, and there were two staff working on his admission. She stated she knew they were verifying all of his narcotic medications with the doctor. LN G stated when a resident admitted , an admission packet came in, and the floor nurse or Administrative Nurse E received it then reviewed it with the provider. On 05/26/26 at 02:43 PM, Administrative Nurse E stated when a resident returned from the hospital, she went through the resident's orders and checked the orders from the hospital to make sure they were (continued on next page)

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