STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265463	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare	128 North Hardesty Kansas City, MO 64123

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the guardian in a timely manner when one resident (Resident #1) overdosed on fentanyl, received two doses of Narcan and was sent to the hospital on [DATE]. Six residents were selected for sample. The facility census was 101 residents. The Administrator was notified on 02/03/26 of the Past Non-Compliance which occurred on 02/01/26. The Director of Nursing (DON) educated floor staff on proper notification, location of emergency numbers, what information to leave on a voicemail, and to notify management when a guardian is contacted. The Social Services Director (SSD) was dedicated for follow up, auditing current contact information, and ongoing confirmation of emergency numbers at each care plan meeting and all admissions. Emergency numbers were moved to the special instructions in the electronic medical record for each resident. The deficiency was corrected on 02/06/26. Review of the facility Notification Policy, dated 2024, showed: -The purpose of this policy was to ensure the facility promptly informs the resident, consults with the resident's representative when there is a change requiring notification. -The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. --Accidents resulting in injury or potential to require physician intervention. --Significant change in the resident's physical, mental or psychosocial conditions such as deterioration in health, mental or psychosocial status, including life-threatening conditions or clinical complications. --Circumstances that require a need to alter treatment. --A transfer or discharge of the resident from the facility. -Residents incapable of making decisions: --The representative would make any decisions that have to be made. --The resident should still be told what is happening to him/her. -Contact information of the resident's legal representative or family member must be recorded and periodically updated. 1.Review of Resident #1's facility admission Record showed:-The resident was admitted on [DATE] with the following diagnoses: paranoid schizophrenia (a psychotic disorder characterized by loss of contact with the environment, by noticeable deterioration in the level of functioning in everyday life), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and personal history of traumatic brain injury. -A court appointed guardian with the guardian's phone number, email, and address was listed. Review of the resident's Progress Notes, dated 02/01/26, showed: -Narcan nasal liquid administered at 6:48 P.M. and at 6:53 P.M. -The resident took a deep breath after the second dose of Narcan. -Guardian notified at 6:58 P.M. Review of facility Suspected Abuse Investigation, dated 02/06/26, showed: -On 02/01/26 at approximately 6:40 P.M. Resident #1 overdosed on an illicit substance. -Narcan was administered twice, and the resident became alert and oriented. -The resident was transported by ambulance to the hospital for further evaluation.-Agencies notified included the Department of Health and Senior Services, the provider, and the resident's guardian. - The resident was put on suboxone and agreed to start meeting (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Narcotics Anonymous every week at the facility on Thursdays. Review of communication emails, dated 02/03/26, showed: -On 02/03/26 the SSD sent email notification to the guardian (Public Administrator (PA) to notify about an appointment for the resident. -The PA responded to SSD the resident contacted the PA about being sent to the hospital for a fentanyl overdose. -No one from the facility contacted his/her emergency cell to notify him/her or any other deputy of the resident's overdose or that he/she was being sent out to the hospital. -The PA tried to call the administrator and DON on 02/03/26 and the call was transferred but no one ever picked up. -The PA requested direct phone numbers for DON and Administrator. -The DON and Administrator were added to the email chain. Review of communication emails, dated 02/04/26, showed: -On 02/04/26 the Administrator advised the PA to contact him/her. -The nurse on shift (02/01/26) called a number and left a voicemail and the Administrator was going to verify which number was called. -The Administrator would make sure the emergency number was updated in the chart. -The Administrator requested clarification of the emergency number for the PA. -The PA clarified the nurse called the office line around 9:00 P.M. on 02/01/26 and didn't call the emergency cell or try to reach anyone to notify the office on 02/02/26 or 02/03/26. -The PA requested the protocol for notifications. -The Administrator responded to the PA, usually they are directed to call the emergency number, the nurse was unable to find the emergency number, so he/she called the office number listed and left a voicemail. -The PA responded: In the event that someone cannot reach a deputy on their emergency phone, they can call the main switchboard (number given) to be routed to another deputy or supervisor. -They are all on call 24/7 for their individual caseloads but are deputized to give consent for all wards under the Public Administrator. -No one notified the PA on 02/01/26 of the resident's overdose or the fact that he/she went to the emergency room (ER). During an interview on 02/09/26 at 10:40 A.M., the Administrator said: -The resident's guardian was notified, but it was not the emergency number. -There has since been clarification of the emergency number for the guardian. -The DON did not have the right emergency number prior to the incident, and it has been updated in the chart. -02/01/26, Sunday night the nurse called the guardian. -The guardian was spoken with on 02/03/26 by Administrator and DON, via email chain for clarification of emergency contact number. During an interview on 02/09/26 at 3:42 P.M., Licensed Practical Nurse (LPN) A said: -He/She contacted the guardian via phone (02/01/26). -There was no answer when he/she called, so he/she left a voicemail. During an interview on 02/10/26 at 1:56 P.M., the SSD said: -He/She will make notifications if he/she is asked to help. -Normally it is nursing that makes the contact with PA, guardians, families and others for notification. -He/She talks to the PAs during the care plan meetings. -He/She does at times speak with the families, PAs, and guardians about the overall care for the residents. -In acute situations, such as narcotic overdose, he/she would only be involved if needed after the fact. During an interview on 02/11/26 at 1:36 P.M., the PA said: -His/Her major concern was that he/she was not contacted at all, the facility had multiple ways to contact the PA office and the facility was provided emergency contact phone numbers. -There was a voicemail left on 02/01/26 in the evening at the office that indicated it was the facility calling about the resident. -There was no indication he/she needed to return a call or anything. -He/She spoke with SSD when he/she took over the resident's case around July 2025 and gave the facility his/her contact information at that time. -If the facility had called the previous PA's emergency number, it would have still been a way to make a notification. -There was no follow up contact the following day (02/02/26) either. During an interview on0 2/11/26 at 5:48 P.M., the Staffing Coordinator said: -He/She expected notifications to be done as soon as an emergency is stabilized (i.e. on the ambulance) notify the responsible party as soon as possible. -If staff cannot make contact, he/she expected staff to keep (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calling and use resources and/or email to ensure contact is made. -Be sure to leave a voicemail to call back. -On the voicemail, leave name, where they are from, and to return a call as soon as possible in reference to a mutual resident. -There is a policy for the notification expectations. During an interview on 02/17/26 at 10:20 A.M., the DON said: -The original PA was the only emergency number listed. -LPN A did leave a voicemail at the number that was called. -The voicemail did say to call the emergency number, but there was no emergency number to call. -Leaving a voicemail was considered a notification. -Information left on voicemail is limited in accordance with HIPPA unless the voicemail specifically indicates it is a secure and confidential voicemail. During an interview on 02/17/26 at 1:57 P.M., the Assistant Director of Nursing (ADON) said: -The nurses have been responsible for following up with guardians and families. -The expectation when leaving a voicemail, should include who is calling from the facility, the resident's name, and to please call back with phone number to be reached at. -He/She felt that would be enough information without giving too much. -Most of the time he/she will just keep calling until he/she gets a hold of someone. 2731567

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate treatment and behavioral health services per policy for three sampled residents (Residents #1, #2, and #3) who had a known history of substance abuse. The facility staff failed develop a plan of care related to behavioral health services for the use of illicit drug use needs based on the residents' Preadmission Screening and Resident Review (PASRR- DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source) and failed to assess and ensure the interventions for the resident were in place and implemented by facility staff after each behavior of illicit drug use. As a result of the facility failure on [DATE] about 6:30 P.M., Resident #3 shared fentanyl (a potential synthetic opioid) smoked off a piece of foil with Resident# 1 (who had a legal guardian) and Resident #2, whom also had a history of substance abuse, and both Resident #1 and Resident #2 became unconscious, had to be administered Narcan and were hospitalized . Six residents were selected for sample. The facility census was 101 residents. The Administrator was notified on [DATE] at 4:18 P.M. of the Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. The undated facility Illicit Drug and Alcohol policy showed: -All illicit drugs, alcohol, and marijuana will be banned from the facility for the safety of all residents. Residents in possession of any of these items could result in the issuance of a 30-day notice, police contact when necessary due to severity, and a call to the physician to advise on administration of orders for medications for residents' safety. -No resident is to bring any form of these substances into the facility at any time. All of these are strictly banned from the premises of the facility. -Any resident who signs out and returns to the facility appearing to be under the influence, physician will be notified and asked how to proceed with orders while resident is under the influence. -If continued use of drugs in the community endanger resident a physician could revoke the standing order for leave of absence for his or her own safety. -Any residents in possession of illicit substances or paraphernalia or caught providing them to another resident could receive a 30-day notice to discharge or police intervention. -Residents who have unsafe behaviors or put other residents at risk secondary to allegedly or knowingly being under the influence will have emergency intervention or police intervention. -Facility offers in house psychological services from a licensed psychiatrist. -Care plans will be created to address specific behaviors such as current illicit drug, marijuana, or alcohol use. -Resident suspected to be under the influence will receive increased monitoring for safety. -Residents' physician will be notified if they appear to be under the influence of a prohibited substance for their safety. -Residents with symptoms of overdose or requiring acute care from a hospital will be sent out to receive services. -Residents with possession of illegal drugs or discovered to be providing to others could receive police intervention or a 30-day notice to discharge. -Residents who appear under the influence will be monitored for their safety and the safety of other residents. -Residents who behaviors put themselves or others at risk could receive police intervention or emergency medical services for the safety. -Residents who habitually violate policy or endanger other residents could receive a 30-day notice. -Monitoring and Visitation Controls: --To protect the health and safety of residents, the facility may implement additional monitoring and supervision measures, which may include: ---Increased observation and safety checks and care plan updates addressing safety risks.---Denial of access to the facility or implementation of supervised visitation for individuals with a known history of bringing illegal substances into the facility. Review of the facility Behavioral Health Services Policy, dated February 2023, showed: -It is (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	other authorized items which could endanger the resident or others. ---Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons. -All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. -Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological intervention. -The Social Services Director (SSD) shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists. 1. Review of Resident #3's PASRR, dated [DATE], showed: -The individual had impairment due to serious mental illness. -The individual had serious difficulty interacting appropriately and communicating effectively with other persons. -This individual had serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions. -The individual had serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings. -The individual had a substance related disorder with most recent abuse within 30 days of the assessment. -Positive for methamphetamine (a lab made stimulant) result on 8/2025. -Psychiatric Assessment History included alcohol abuse, polysubstance dependence (the intentional or unintentional use of three or more different classes of psychoactive substances within a short period), and Methamphetamine abuse. -Per hospital note, [DATE] urine drug screen was positive for opiates and benzodiazepines (a class of central nervous system depressant drugs) with diagnosis of polysubstance abuse. -A skilled care facility was recommended to ensure sobriety, 24-hour supervision, and appropriate medical and psychiatric treatment. -Client would benefit from cessation program (the voluntary or involuntary stopping, discontinuing, or ending of a process, habit, or physical function). -Client would benefit from substance abuse program, including: substance abuse services community-based substance use treatment, 12 step substance use program, and residential/intensive substance use treatment/rehabilitation services. Review of the resident's undated admission Record showed the resident admitted on [DATE] with diagnoses including opioid abuse (a chronic, treatable medical condition characterized by a problematic pattern of using opioids-such as prescription pain relievers (oxycodone, hydrocodone, fentanyl) or illegal drugs like heroin-that leads to significant impairment or distress) and other psychoactive substance abuse. -The resident did not have a legal guardian. Review of the resident's Order Summary Report, dated [DATE], showed an order, dated [DATE], for Buprenorphine (Suboxone - a Schedule III medication used to treat opioid use disorder (addiction) by reducing cravings and withdrawal symptoms) sublingual tablet 8 milligram (mg) give one tablet sublingually two times a day for chronic pain. Review of the resident's medical record showed:-No risk assessments related to substance use/abuse. -No documentation of Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) resources, education or attendance. -No substance abuse programming, no substance abuse services community-based substance use treatment, no 12-step substance use program, and no residential/intensive substance use treatment/rehabilitation services as recommended by the resident's PASRR. Review of the resident's undated Care Plan showed:-The resident received opioid medication for chronic pain.-No identified problem, goal, or interventions for illicit substance use/abuse.-No identified problem, goal, or interventions from the PASRR recommendations. Review of the facility sign in and out sheets for [DATE] showed the facility had no record at all for a visitor log or a resident sign in or out. Review of the resident's progress note, dated [DATE], showed: -He/She brought illicit drug paraphernalia into the building. -He/She was placed on a 30-day restriction. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-There was no documentation to describe what the 30-day restriction was supposed to be for the resident. -There was no documentation of facility staff education related to the resident restriction. Review of the resident's care plan, updated [DATE], showed:-He/she had a behavior problem with possession of illegal substances and paraphernalia. -He/she was placed on restriction. -The resident re-educated that not following facility policy would not be tolerated and consequences of continued noncompliance. -There was no documentation on what staff interventions should look like with the LOA (leave of absence) restriction. Review of the facility sign in and out sheet for [DATE] showed the facility had no record at all for a visitor log or a resident sign in or out. Review of the resident's progress note, dated [DATE] at 5:32 A.M., showed: -He/She was found again with drug paraphernalia. -It was documented the resident was given education, but there was no documentation of what the education to the resident was. -He/She was placed on supervised visitation and LOA restriction. -There was no documentation of supervised visitation and LOA restriction or documentation of staff training as to what the resident's LOA restriction was to be. -There was no assessment of the resident's substance use and or resources the resident needed completed. Review of the resident's progress note, dated [DATE] at 8:54 A.M., showed: -He/she was given a 60-day restriction and 30-day discharge notice. -There was no documentation of staff education as to what the facility staff were supposed to do for the resident's 30 day or 60-day restriction. Review of the resident's care plan, updated [DATE], showed:-LOA had been restricted for 60 days for not following facility policy. -Additional items confiscated from the resident. -30 day discharge given for noncompliance. Review of the facility sign in and out sheets for [DATE] showed the facility had no record at all for a visitor log or a resident sign in or out. During an interview on [DATE] at 10:40 A.M., the Administrator said:-The resident had been caught with drug paraphernalia on [DATE] and [DATE] which resulted in a 30 day discharge notice.-The resident was placed on restriction and was required to have someone sign him/her out due to the paraphernalia. -The resident was placed on restriction per the medical director in accordance with the facility Illicit Drug and Alcohol policy.-The facility offered AA and NA programs led by the Administrator. During an interview on [DATE] at 10:50 A.M., the Director of Nursing (DON) said: -The resident was caught on [DATE] with drugs on his/her person and was given a 30 day discharge notice for violating the facility drug policy. -The resident was caught with contraband at one point and was restricted for 30 days. -The resident restriction included having someone sign him/her out when out of the building. During an interview on [DATE] at 3:42 P.M., Licensed Practical Nurse (LPN) A said: -Resident #3 was on restriction after being caught with pipes and meth and had to have someone sign him/her out and they had to show their ID for him/her to leave with them. They were not told to document who the resident left with. -If residents were caught with alcohol or drugs they get restriction. -If anybody has bags, they check the bags, but they do not search the resident themselves. -No special procedures were expected outside of the sign out by another person for a resident on restriction. Review of the facility sign in and out sheets for [DATE] showed the facility had no record at all for a visitor log or a resident sign in or out. Review of the resident's progress note, dated [DATE] at 1:39 P.M., showed: -The SSD left the resident a voicemail checking to see if the resident plans on returning to the acility. -The SSD will follow up again tomorrow. -No documentation that anyone signed the resident out. Review of the resident's progress note, dated [DATE], showed staff documented the resident continued to leave facility on LOA without wheelchair. Further review showed no documentation the resident was signed out of the facility by anyone. Review of the resident's progress note, dated [DATE], showed he/she was signed out of the facility by a family member. Further review showed there was no return date or time documented. Review of the resident progress note, dated (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	[DATE], showed he/she returned to the facility between 1:00 A.M. and 2:00 A.M. 2. Review of Resident #1's PASARR, dated [DATE], showed: -Psychiatric Assessment History including alcohol dependence. -No recent use. -Required 24-hour supervision for his/her safety and the safety of others. -Required medication administration, was a high fall risk, and cannot manage his/her own medications or medical diagnoses. -Remains safe in a skilled care facility. -Due to his/her chronic medical and psychiatric conditions as well as his/her inability to care for him/herself, he/she required around-the-clock nursing care. Review of the resident's admission Record showed Resident #1 was admitted on [DATE] with a court appointed guardian and diagnoses including paranoid schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others), bipolar disorder (a chronic mental health condition causing extreme, often debilitating, shifts in mood, energy, and activity levels, alternating between manic highs and depressive lows), and personal history of traumatic brain injury. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated [DATE], showed the resident was cognitively intact. Review of the resident's medical record showed:-No risk assessments related to substance use/abuse. -No documentation of NA or AA resources, education, or attendance. Review of the resident's undated Care Plan showed:-No focus, goals, or interventions for alcohol dependence. -Resident was assessed to have increased depression due to overall decline followed up by relocation to a less restrictive environment. -Limited insight and judgement and the need to for a safe place to live with 24 hour supervision. 3. Review of Resident #2's admission Record showed the resident was admitted [DATE] with diagnoses including schizophrenia and weakness. Review of the resident's PASRR, dated [DATE], showed: -Substance related disorder with most recent use within 30 days of assessment. -Diagnoses relevant to functional and/or skilled nursing needs include history of substance abuse. -Psychiatric Assessment History diagnoses included cocaine dependence, alcohol dependence, other psychoactive substance abuse, and unspecified, alcohol-induced disorder. -[DATE] emergency department records indicate depression with complaint of drug use and someone stole his/her medications.-admitted to cocaine use on [DATE]. -Required 24-hour protective oversight, cannot be without supervision at any time. -Psychiatric history complicated by a history of polysubstance abuse. -His/Her history of psychosis, suicide attempt, and polysubstance use indicated significant risk for decompensation in the absence of structured oversight. -Nursing facility placement offers the level of care necessary to support his/her continued safety, prevent relapse, and promote overall well-being. Review of the resident's MDS, dated [DATE], showed the resident was cognitively intact. Review of the resident's undated Care Plan showed no focus, goal, or interventions for diagnoses of cocaine dependence, alcohol dependence, other psychoactive substance abuse, and unspecified, alcohol-induced disorder. Review of the resident's medical record showed:-No risk assessments related to substance use/abuse.-No documentation of NA or AA resources, education or attendance. 4. Review of the facility Suspected Abuse Investigation, dated [DATE], showed: -On the night of [DATE] Resident #3 was actively using a substance in his/her room when Residents #1 and #2 came into the room. -Resident #3 told Residents #1 and #2 to go ahead and take a hit of the illicit substance. -Resident #3 told Resident #1 to take a hit. -Resident #2 held the foil as Resident #3 used the illicit substance. -Resident #2 then used the illicit substance and both Resident #2 and #1 passed out. -Resident #1 used first with the help of Resident #2. -Resident #2 then used the illicit substance and both residents became unconscious. -Two residents overdosed in the facility and required Narcan on [DATE] at approximately 6:40 P.M. -Resident #3 came out of the room at approximately 6:54 P.M. yelling to the nurses the residents in his/her room needed Narcan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265463	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare	128 North Hardesty Kansas City, MO 64123

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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-Licensed Practical Nurse (LPN) A and B rushed to the residents. -LPN B assessed for a pulse on Resident #1 and Resident #2 while LPN A obtained the Narcan. -Residents #1 and #2 had Narcan administered and emergency medical services (EMS) was called. -Resident #1 became alert and oriented with the Narcan administration, Resident #2 was going in and out of orientation. -EMS transported Resident #1 and #2 to the hospital. Review of Resident #1's Nurses Note, dated [DATE] at 6:58 P.M., showed:-LPN B had just given report to the oncoming shift and Resident #3 came up to the nursing station at about 7:00 P.M. and said, I need Narcan.- LPN B asked Resident #3 what they needed Narcan for. Resident #3 stated that two residents were in his/her room unconscious. - Resident #3 stated, I woke up and found them that way, I tried to splash water on them, but they aren't waking up.- LPN B ran down the hall to Resident #3's room and noticed Resident #1 unconscious in a wheelchair. - LPN B called to Resident #1 and he/she did not respond. - LPN B advised oncoming nurse to call EMS. - LPN B checked Resident #1 for pulse and noted strong carotid pulse. - LPN B retrieved Narcan from the nurse cart and Resident #1 was given 1 dose of Narcan. - Resident #1 didn't respond to 1st dose, so another was administered shortly after. - LPN B proceeded to do a sternal rub on Resident #1. -Resident #1 responded to the second dose of Narcan. Resident #1 came to and stated he/she was okay.- LPN B informed Resident #1 of unconsciousness and asked the resident what he/she took and the resident stated, I smoked meth. -EMS arrived and Resident #1 was transferred via stretcher to hospital for additional treatment and care. -Director of Nursing (DON) and Administrator notified, guardian notified. Managers and Nurse Practitioner (NP) notified as well. Review of Resident #1's Administration Note, dated [DATE] at 6:48 P.M. through 6:53 P.M., showed:-Narcan nasal liquid 4 MG/0.1ML 1 inhalation in nostril every 2 minutes as needed (PRN) for overdose up to three doses.-Took a breath opened eyes and continued not to respond. -6:53 P.M. administered another dose of Narcan. Resident took a deep breath opened eyes and said, I want Taco Bell.-Second dose PRN Administration at 6:53 P.M. was effective. Review of Resident #2's Nurses Note, date [DATE] at 6:58 P.M., showed:-LPN B had just given report to the oncoming shift and Resident #3 came up to the nursing station at about 1900 (7:00 P.M.) and said, I need Narcan.-LPN B asked Resident #3 what they needed Narcan for. Resident #3 stated that two residents were in his/her room unconscious. -Resident #3 stated, I woke up and found them that way, I tried to splash water on them, but they aren't waking up.-LPN B noticed Resident #2 unconscious on the floor. -LPN B called to Resident #2 and no response. -LPN B advised oncoming nurse to call EMS. -LPN B checked for pulses and noted carotid pulse. -LPN B got Narcan from the nurse cart and Resident #2 was given 1 dose of Narcan. -Resident #2 didn't respond to 1st dose so another was administered. -LPN B and co-nurse continued with sternal rub on Resident #2. -Resident #2 responded to second dose of Narcan but still in and out of consciousness. -EMS arrived and Resident #2 was transferred via stretcher to hospital for additional treatment. -DON, NP, and Administrator notified. Review of Resident #1's hospital records, dated [DATE], showed: -Admit reason was overdose. -Presented to the emergency department by EMS. -He/She lived in a nursing facility. -That night he/she was smoking fentanyl with another resident. They both accidentally overdosed and were found unresponsive. -EMS arrived at the scene and administered 8 mg of Narcan and he/she woke up appropriately. -He/She did not intend to hurt him/herself and was very inexperienced with smoking fentanyl. -He/She had never done fentanyl before and wanted to see what the high was like. During an interview on [DATE] at 4:21 P.M., Resident #1 said:-He/She was aware of the drug being fentanyl, however, he/she had never consumed it before. -He/She only had one hit and it caused him/her to go unconscious. -The last thing he/she remembered was looking at the foil and saw the smoke coming out of the straw, then looked at Resident #2 and blacked out. -The next thing he/she remembered was seeing LPN A. -He/She had never had Narcan (continued on next page)

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	265463	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare	128 North Hardesty Kansas City, MO 64123

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	before. -He/She thought Resident #3 was on restriction and was not sure where Resident #3 got the fentanyl. -18 years ago his/her drug of choice was meth and he/she broke sobriety to experience the high again. Review of Resident #2's hospital records, dated [DATE], showed: -Admit reason was pulmonary edema and drug overdose on [DATE]. -History of present illness was a past medical history of polysubstance abuse who presents with reported fentanyl overdose at his/her nursing home. -Recent hospitalization last month for alcohol-induced pancreatitis. -That evening he/she planned to smoke methamphetamines with a friend but instead was given fentanyl which he/she accidentally overdosed on. -He/She received several doses of Narcan with some response. -He/She was still very lethargic and nodded yes when confirming fentanyl overdose. -Current use of liquor, cocaine, methamphetamines, and fentanyl. During an interview on [DATE] at 2:51 P.M., Resident #2 said: -He/She recalled having to go to the hospital. -He/She said it was a sad story, he/she didn't know what it was that he/she smoked. -When they passed it to him/her, Resident #3 almost dropped the foil. -Resident #3 kept passing out and waking up. -He/She said man can I get some, because he/she thought it was meth. -When he/she hit it, he/she felt something in his/her brain, thinking it was from the high, he/she hit it again, then started fading away and blacked out. -He/She was out, he/she was dead. -When the staff found him/her dead they found Resident #1. -He/She was really weak when he/she woke up and the ambulance man said he/she was dead. -He/She knew Resident #3 was on restriction, so he/she didn't know Resident #3 could still go out. -Residents #3 and #2 were smoking in front of him/her and then he/she asked for it. -He/She never had hard drugs like that. -If he/she would have known what it was, he/she would not have smoked it. -He/She was told it was fentanyl after he/she overdosed. -He/She had never used fentanyl and had no desire to do fentanyl. -If he/she would have known or had done fentanyl before he/she would have been more careful. -He/She blacked out and fell on the floor by the sink. -Resident #3 had asked to use his/her phone and when he/she went to get his/her phone and came back he/she saw Resident #3 and #1 smoking and passing the foil back and forth.-For Resident #2 when on restriction, he/she cannot leave and was not allowed to go into other's rooms. Resident #2 was placed on restriction after the overdose. During an interview [DATE] at 2:25 P.M., Resident #3 said: -He/She did say they found a pipe in his/her trashcan, which he/she alleged was his/her roommates. -He/She was sleeping and woke up to two residents (Resident #1 and #2) passed out in his/her room. -Two people don't overdose at the same time. -He/She got the nurses who revived the residents and sent them to the hospital. -He/She denied having anything to do with it. -He/She denied history drug use. -Initially he/she had no idea why he/she was on restriction, the reason he/she had a notice was due to an assault. -He/She admitted to being at Denny's on [DATE] and then took an Uber back late at night on Saturday. -He/She denied substance use, but admitted to being on fentanyl forever. -He/She had psychiatric support at [AGE] years old. -The staff said he/she gave Resident #1 and #2 the fentanyl, because the staff don't want to make the Administrator mad. -He/She wouldn't let two people overdose; it wouldn't serve any purpose for him/her to let them get high. -He/She alleged the only reason any of this happened was because nobody wants to make the Administrator mad. -He/She did throw water on Resident #1 and Resident #2, and the cup had chocolate milk in it. He/she also tried to give Resident #1 and Resident #2 mouth to mouth and then he/she went to get help. -He/She told staff help was needed and to bring Narcan. He/She knew they needed Narcan because he/she had seen other people who needed Narcan before. During an interview on [DATE] at 9:03 P.M., CNA C said: -He/She let Resident #3 in the facility on [DATE] at around 2:00 A.M.-He/She did not notice anything different about Resident #3 other than the resident was complaining about money. -Resident #3 was already at the door when he/she saw the resident at the door, so he/she had no idea how the resident arrived at the facility. -The (continued on next page)

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