

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/18/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
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S 000	INITIAL COMMENTS The following citations represent the findings of the licensure resurvey for the above named facility conducted on 07/13/22-07/18/22.	S 000		
S 230 SS=D	26-39-102 (b) (c) Admission Advanced Directives Resident Rights b) At the time of admission, adult care home staff shall inform the resident or the resident ' s legal representative, in writing, of the state statutes related to advance medical directives. (1) If a resident has an advance medical directive currently in effect, the facility shall keep a copy on file in the resident ' s clinical record. (2) The administrator or operator, or the designee, shall ensure the development and implementation of policies and procedures related to advance medical directives. (c) The administrator or operator, or the designee, shall provide a copy of resident rights, the adult care home's policies and procedures for advance medical directives, and the adult care home's grievance policy to each resident or the resident's legal representative before the prospective resident signs any admission agreement. This REQUIREMENT is not met as evidenced by: KAR 26-39-102(b)(1) The facility reported a census of 38 residents with three included in the sample. Based on interview and record review the administrator failed to ensure a copy of one resident's advance medical directive was in the resident's clinical record.	S 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 230	Continued From page 1 Findings included: - Record review for R714 revealed an admission date of 01/06/22 with the following diagnoses: osteoarthritis and chronic pain. The 01/06/22 Admission "Functional Capacity Screen" (FCS) identified R714 required physical assistance with bathing and was independent with dressing, toileting, transfers, walking/mobility, and eating. She required supervision with management of medications and physical assistance with management of treatments. The 01/06/22 Admission "Negotiated Service Agreement" directed facility staff to provide R714 with physical assistance with bathing by turning the water on and off, washing and drying her back and feet, and washing her hair. The 01/06/22 Admission Healthcare Service Plan (HSP) directed facility staff to provide three meals a day. All other areas (nine) were left blank. R714's record lacked documentation of her advance medical directive. On 07/18/22 at approximately 04:45 PM Administrative Staff C confirmed R714's advance medical directive was not on her chart. The administrator failed to ensure a copy of R714's advance medical directive was in her clinical record.	S 230		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that	S3026		

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S3026	Continued From page 2 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: 26-41-101(f)(1)(B) The facility reported a census of 38 residents with three residents included in the sample. Based on observation, interview, and record review the administrator failed to protect one resident from neglect by failing to secure all exit doors. This failure resulted in immediate jeopardy when cognitively impaired Resident (R)713 left the facility through the door with a broken lock from the main hallway to the back hall/laundry area, exited the unlocked door to the outside, and walked toward the street. Findings included: - Record review for (R) 713 revealed an admission date of 10/09/19 with the following diagnoses: dementia, anxiety, depression, and head trauma. The 10/09/20 (most recent) Annual "Functional Capacity Screen" (FCS) identified R713 was independent with walking/mobility. She had difficulties with short-term and long-term memory memory/recall, and decision making, and was marked for falls, impaired vision, impaired hearing, and inappropriate behavior.	S3026		

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S3026	Continued From page 3 The 10/02/20 (most recent) Annual "Negotiated Service Agreement" (NSA) identified R713 was independent with a walker for walking/mobility, and facility staff would provide encouragement to use her walker in her room for falls. The NSA failed to identify what facility staff would provide to assist R713 with cognition, and what facility staff would provide to assist with impaired vision, impaired hearing, and inappropriate behavior. The 10/02/20 (most recent) "Healthcare Service Plan" (HSP) directed facility staff that R713 was independent with walker for ambulation/transfers and she wore glasses for impaired vision. The HSP lacked direction for facility staff to provide interventions for cognition, falls, impaired hearing, and inappropriate behavior. The 11/02/20 at 06:30 PM "Progress Note" by unidentified staff documented they received a phone call from an unidentified Certified Medication Aide (CMA) that R713 ambulated with her walker out of the building at approximately 06:10 PM. A neighbor reported a resident was at their house. The CMA went to the neighbor's house, found R713, and assisted with ambulation back to the facility. The 11/02/20 at 06:45 PM "Progress Note" by unidentified staff documented before R713 was found by the neighbor at approximately 06:10 PM, she was last seen at 05:30 PM at the dining table eating dinner. Staff were instructed to do 15-minute checks of resident and the executive director put an alarm on the front door. Observation on 07/13/22 at 11:10 AM revealed there was a locked keypad door from the main hallway to a back hall/laundry area with another	S3026		

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S3026	Continued From page 4 door leading to the outside. On 07/13/22 at 11:10 AM Administrator B stated the door to the outside was closed and locked at night but remained unlocked during the day. The door was not alarmed and was accessible to anyone who had the keypad code to the door from the main hallway to the back hall/laundry area or if the lock was broken. On 07/13/22 at 11:16 AM Administrator B stated all exit doors in the facility were alarmed and the front door was keypad locked. Observation on 07/13/22 at 11:19 AM revealed the east hallway exit door was unlocked and the alarm did not sound upon opening. Observation on 07/13/22 at 11:22 AM revealed the north hallway exit door was unlocked and the alarm did not sound upon opening. On 07/13/22 at 11:22 AM Administrator B stated she was not aware of a system to check the door alarms. She would ask maintenance staff if they had a plan in place. On 07/13/22 at 11:28 AM Administrator B stated maintenance staff F had the door alarms temporarily disarmed for going in and out of the building for maintenance. The alarms were back on now. On 07/13/22 at 12:10 PM maintenance staff F stated he disarmed the door alarms only during times when residents were moving in or out of the facility or for maintenance reasons. The alarms were usually disarmed for one-half to one hour only. The doors were disarmed today because someone was at the facility to work on a	S3026		

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S3026	Continued From page 5 drainpipe. On 07/13/22 at 01:20 PM R715 stated the door from the main hallway to the back hallway/laundry area had been unsecured for months even though she reported it multiple times. The door had been open with a broken lock. The door was replaced with a new door with a keypad lock yesterday (07/12/22). On 07/13/22 at 01:24 PM an unidentified resident stated she was looking out her window on 07/06/22 and saw R713 standing with her walker down the street. (CMA) H and housekeeping staff G ran down the street and pushed R713 back in a wheelchair. On 07/13/22 at 01:32 PM housekeeping staff G stated R713 got out of the facility last Wednesday (07/06/22). She saw her out the window while she was cleaning a resident's room. She ran and told the CMA H and they both ran out to get R713. On 07/13/22 at 01:39 PM CMA I stated she worked until 02:00 PM on 07/06/22 and did not realize R713 had left the facility. She always kept an eye on R713 because she was a fall risk. She had seen R713 wandering the facility in the past and try to open the doors. A new keypad was replaced on the door the laundry area today. The door had been unlocked for three months. It was possible R713 could have gone out that door, but she did not know about it. On 07/13/22 at 01:42 PM Administrator B stated it had not been reported to her that a resident had wandered out of the facility. If it was reported to her, she would have reported it to the Kansas Department for Aging and Disability Services (KDADS) and investigated how the resident was	S3026		

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S3026	Continued From page 6 able to get out of the building. The door to the back hallway/laundry area was without a lock for a few weeks. It was on the list for maintenance staff to fix. On 07/13/22 at 01:46 PM maintenance staff F stated the door wasn't locked for about two months. The keypad lock wasn't working and the push lock on the doorknob quit working because the door was probably seven years old. The broken lock was on his list, but he had to wait for the money to get a new door and lock. He received the money two weeks ago but just found the time to replace the door yesterday and program the new lock today. On 07/13/22 at 02:52 PM CMA H stated she worked on 07/06/22 during the evening shift. Carpet cleaners were in the building and opening the front and back doors. Housekeeping staff G alerted her R713 was walking down the parking lot. They both ran out and stopped R713 just before stepping into the street. On 07/13/22 at 03:17 PM CMA H stated she did not report the incident to the administrator or director of nursing (DON) because she assumed she did not need to report it because the resident was found and brought back into the facility and was fine. Observation on 07/13/22 at 04:00 PM revealed R713 sat in the common area on the sofa with her rolling walker nearby looking at a magazine. She was able tell her first name and stated she was reading a book and forgot what day it was. She transferred herself off the sofa and ambulated with her walker down the hall without difficulty.	S3026		

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S3026	Continued From page 7 On 07/13/22 at 04:08 PM Administrator B stated R713 was confused and independently mobile. She exhibited exit-seeking behavior occasionally wanting to go home. On 07/13/22 at 04:12 PM CMA J stated R713 was sometimes confused. She exhibited exit-seeking behavior occasionally. She usually sat in the common area and would try to push the front door open. When the door alarmed, she looked around because she knew someone would come. The door from the main hallway to the back hall/laundry area was broken for "at least a month". The undated facility's "Elopement" policy documented "Employees are to be proactive in the prevention of elopements. All elopements will be reported immediately to the Administrator or designee and will be documented appropriately. Elopement is defined as: . . . This may include the wandering away of a confused resident. . . Residents at risk of elopement or wandering are to be monitored more frequently if needed. . . " The undated facility's "Staff Reporting" policy documented "It is the policy of this facility that staff report any unusual incidents, behaviors or change in conditions to their supervisor as soon as possible. These are to include the following: . . . A resident who is attempting to elope from the property. . . Any building issue which endangers a resident's well being." The administrator/operator failed to protect R713 from neglect when she left the facility without staff knowledge and was found in the parking lot near the street by staff. On 07/13/22 at 05:06 PM Administrator B was	S3026		

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S3026	Continued From page 8 informed of the findings which resulted in immediate jeopardy regarding a confused resident exiting the facility through a door with a broken lock and/which was not reported to the appropriate staff. Administrator B submitted an abatement plan which included the following: The door was replaced with a new keypad on 07/12/22. The keypad was programmed on 06/13/22 and all staff were informed of the new number The nursing staff will conduct 15-minute checks on R713 to ensure her safety for the next three days and hourly checks moving forward. All staff will be trained on what to report to their supervisor by 07/15/22. The immediate jeopardy was abated on 07/13/22 at 06:12 PM based on the facility's plan of correction and approved by the department.	S3026		
S3080 SS=D	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 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	S3080		

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S3080	Continued From page 9 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) The facility reported a census of 38 residents with three residents included in the sample. Based on observation, interview, and record review the administrator failed to record all findings of Resident (R) 714's functional capacity on a screening form. Findings included: - Record review for R714 revealed an admission date of 01/06/22 with the following diagnoses: osteoarthritis and chronic pain. The 01/06/22 Admission "Functional Capacity Screen" (FCS) identified R714 required physical assistance with bathing and was independent with dressing, toileting, transfers, walking/mobility, and eating. She required supervision with management of medications and physical assistance with management of treatments. The 01/06/22 "Admission FCS" was left blank for the following: bladder incontinence, cognition, communication, falls/unsteadiness, impaired vision, impaired hearing, impaired decision making, wandering, inappropriate behavior, and medical appliances R714 required. The 01/06/22 Admission "Negotiated Service Agreement" directed facility staff to provide R714	S3080		

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S3080	Continued From page 10 with physical assistance with bathing by turning the water on and off, washing and drying her back and feet, and washing her hair. The 01/06/22 Admission Healthcare Service Plan (HSP) directed facility staff to provide three meals a day. All other areas (nine) were left blank. Observation on 07/13/22 at 02:46 PM revealed R714 standing in the common area watching resident's return from an outing. She ambulated down the hall to her room and sat down on her bed without difficulty. On 07/18/22 at 02:37 PM Administrative Staff C confirmed the areas on R714's FCS were left blank. The 05/2009 facility's "Resident Functional Capacity Screening" policy documented "On or before each individual's admission to an assisted living facility. . . a licensed nurse, a licensed social worker, or the administrator or operator shall 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 failed to record all findings of Resident (R) 714's functional capacity on a screening form.	S3080		
S3081 SS=D	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:	S3081		

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S3081	Continued From page 11 (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) The facility reported a census of 38 residents with three residents included in the sample. Based on observation, interview, and record review for one resident the administrator failed to conduct a screening to determine the individual's functional capacity based on their needs and preferences every 365 days or following a significant change in condition. Findings included: - Record review for Resident (R) 713 revealed an admission date of 10/09/19 with the following diagnoses: dementia, anxiety, depression, and head trauma. The 10/09/20 Annual "Functional Capacity Screen" (FCS) identified R713 required physical assistance with bathing and dressing. She was independent with toileting, transfers, walking/mobility, and eating. She was unable to perform management of medications and treatments and required supervision for bladder incontinence. She had difficulties with short-term and long-term memory memory/recall, and decision making, and was marked for falls, impaired vision, impaired hearing, and inappropriate behavior.	S3081		

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S3081	Continued From page 12 The 10/02/20 Annual "Negotiated Service Agreement" (NSA) identified facility staff would provide assistance of one staff for bathing two times a week and dressing each morning and evening. R713 was independent with a walker for walking/mobility. Facility staff would provide management of medications. R713 was not receiving treatments at that time. She wore briefs for incontinence and facility staff would provide encouragement to use her walker in her room for falls. The NSA failed to identify what facility staff would provide to assist R713 with cognition, and what facility staff would provide to assist with impaired vision, impaired hearing, and inappropriate behavior. The 10/02/20 "Healthcare Service Plan" (HSP) directed facility staff to provide R713 with physical assistance with showers on Mondays and Thursdays; that resident was independent with walker for ambulation/transfers and she wore glasses for impaired vision. The HSP lacked direction for facility staff to provide interventions for cognition, falls, impaired hearing, and inappropriate behavior. R713's record lacked documentation of an "Annual FCS" completed since 10/09/20 which as of 07/13/20 was 643 days, 278 days past due. The 11/02/20 at 06:30 PM "Progress Note" by unidentified staff documented they received a phone call from the CMA that R713 ambulated with her walker out of the building at approximately 06:10 PM. A neighbor reported a resident was at their house. The CMA went to the neighbor's house, found R713, and assisted with ambulation back to the facility.	S3081		

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S3081	Continued From page 13 The 11/02/20 at 06:45 PM "Progress Note" by unidentified staff documented before R713 was found by the neighbor, she was last seen at 05:30 PM at the dining table eating dinner. Staff were instructed to do 15-minute checks of resident and the executive director put an alarm on the front door. R713's record lacked documentation of a "Significant Change FCS" after her elopement on 11/02/20 to identify any changes in her functional capacity which indicated the requirement of goods and services be provided which were reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. On 07/18/22 at 12:28 PM Administrative Staff C stated she completed a FCS and Negotiated Service Agreement (NSA) yearly or anytime there was a significant change. She completed a "Significant Change FCS" for R713 because she required a change for staff to cut up her meal during meals. Record lacked an updated FCS. The 05/2009 facility's "Resident Functional Capacity Screening " policy documented "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. . . " The administrator failed to conduct a screening to determine the individual's functional capacity based on their needs and preferences every 365 days or following a significant change in condition.	S3081		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/18/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
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S3092	Continued From page 14	S3092		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement 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; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d) The facility reported a census of 38 residents with three residents included in the sample. Based on interview and record review for one resident the administrator failed to complete a "Negotiated Service Agreement" (NSA) based on the resident's "Functional Capacity Screen," service needs, and preferences every 365 days or following a significant change in condition. Findings included: - Record review for Resident (R) 713 revealed an admission date of 10/09/19 with the following diagnoses: dementia, anxiety, depression, and head trauma.	S3092		

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S3092	Continued From page 15 The 10/09/20 Annual "Functional Capacity Screen" (FCS) identified R713 required physical assistance with bathing and dressing. She was independent with toileting, transfers, walking/mobility, and eating. She was unable to perform management of medications and treatments and required supervision for bladder incontinence. She had difficulties with short-term and long-term memory memory/recall, and decision making, and was marked for falls, impaired vision, impaired hearing, and inappropriate behavior. The 10/02/20 Annual "Negotiated Service Agreement" (NSA) identified facility staff would provide assistance of one staff for bathing two times a week and dressing each morning and evening. R713 was independent with a walker for walking/mobility. Facility staff would provide management of medications. R713 was not receiving treatments at that time. She wore briefs for incontinence and facility staff would provide encouragement to use her walker in her room for falls. The NSA failed to identify what facility staff would provide to assist R713 with cognition, and what facility staff would provide to assist with impaired vision, impaired hearing, and inappropriate behavior. The 10/02/20 "Healthcare Service Plan" (HSP) directed facility staff to provide R713 with physical assistance with showers on Mondays and Thursdays; that resident was independent with walker for ambulation/transfers and she wore glasses for impaired vision. The HSP lacked direction for facility staff to provide interventions for cognition, falls, impaired hearing, and inappropriate behavior.	S3092		

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S3092	Continued From page 16 R713's record lacked documentation of an "Annual NSA" completed since 10/02/20 which as of 07/13/20 was 650 days, 285 days past due. The 11/02/20 at 06:30 PM "Progress Note" by unidentified staff documented they received a phone call from the CMA that R713 ambulated with her walker out of the building at approximately 06:10 PM. A neighbor reported a resident was at their house. The CMA went to the neighbor's house, found R713, and assisted with ambulation back to the facility. The 11/02/20 at 06:45 PM "Progress Note" by unidentified staff documented before R713 was found by the neighbor, she was last seen at 05:30 PM at the dining table eating dinner. Staff were instructed to do 15-minute checks of resident and the executive director put an alarm on the front door. R713's record lacked documentation of a "Significant Change NSA" after her elopement on 11/02/20 to identify any changes in her functional capacity which indicated the requirement of goods and services be provided which were reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. On 07/18/22 at 12:28 PM Administrative Staff C stated she completed an FCS and NSA yearly or anytime there was a significant change. She completed a "Significant Change FCS and NSA" for R713 because she required a change for staff to cut up her meal during meals. Record lacked an updated NSA. The 05/2009 facility's "Negotiated Service Agreement" policy documented "Each	S3092		

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S3092	Continued From page 17 administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement 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. . . " The administrator failed to complete an "NSA" based on R713's "FCS," service needs, and preferences every 365 days and following a significant change in her condition.	S3092		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 38 residents with three residents included in the sample. Based on observation, interview, and record review the administrator failed to ensure one resident's "Negotiated Service Agreement" (NSA) identified who was responsible for the administration and	S3186		

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S3186	Continued From page 18 management of select medications. Findings included: - Record review for R714 revealed an admission date of 01/06/22 with the following diagnoses: osteoarthritis and chronic pain. The 01/06/22 Admission "Functional Capacity Screen" (FCS) identified R714 required supervision with management of medications. The 01/06/22 Admission "Negotiated Service Agreement" failed to identify who was responsible for management of medications including select medications R714 self-administered. The 05/2022 "Physician's Order Sheet" documented "May keep at bedside. May self-administer" the following medications: Aspercreme lidocaine (topical pain medication) 4 percent (%), Cepacol (sore throat medication) lozenges 15-3.6 milligrams (mg), and Icy Hot No Mess Liquid (topical pain medication). The 01/28/22 "Progress Note" documented "R714 became agitated with staff because she wants to have her medication in her room. It was explained that she did not pass the "Self Medication Assessment". Attempted to explain, Linda became agitated and accused this writer of stealing her ID cards." On 07/18/22 01:36 PM resident had a tube of Hydrocortisone cream on a lampstand next to her recliner. On 07/18/22 01:36 PM stated that she did take some of her medications by herself such as topical rubs and throat lozenges.	S3186		

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S3186	Continued From page 19 On 07/18/22 at 01:54 PM Administrative Staff C stated the doctor gave an order for some Aspercreme and cough drops that she could keep at her bedside. Stated she would note any medications on the NSA if the resident had some self-administrated medications. Stated she expected all the boxes of the FCS to be completed and it should be signed by the nurse completing the screen. The 05/2009 facility's "Medication Management" policy documented "Any resident who self-administers may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications." The administrator failed to ensure R714's NSA identified who was responsible for the administration and management of select medications.	S3186		
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;	S3280		

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S3280	Continued From page 20 and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility reported a census of 38 residents. Based on interview and record review the administrator failed to provide quarterly reviews of the facility's management plan with employees and residents. Findings included: - Review of the emergency preparedness records provided by the facility revealed the lack of quarterly reviews of the facility's management plan with employees and residents. On 07/13/22 at 12:27 PM Administrative Staff B stated quarterly emergency management plan reviews were not done. They only did fire drills with staff and residents. On 07/13/22 at 03:17 PM Certified Medication Aide (CMA) H stated the last emergency review was too long ago she did not remember when it was. On 07/13/22 at 04:12 PM CMA J stated staff received training "about a month ago" regarding elopement.	S3280		

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S3280	Continued From page 21 The 05/2009 facility's "Disaster and Emergency Preparedness" policy documented "Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: . . . quarterly review of the facility's management plan with employees and residents. . . ." The administrator failed to provide quarterly reviews of the facility's management plan with employees and residents.	S3280		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident 's family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d)	S3298		

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S3298	Continued From page 22 The facility had a census of 38 residents. All 38 residents ate food prepared in the same kitchen. The administrator failed to ensure food items were served at the proper temperature. Findings included: - On 07/13/22 at 11:32 AM Dietary Manager D stated there was no food temperature log yet because he just started working at the facility about a month and a half ago. Dietary Manager D stated he took food temperatures, but he could not find an existing food temperature log and he did not have time to sit down and create a new temperature log. A policy concerning food storage temperatures was requested from the facility on 07/18/22 at 03:57 PM but no policy was provided. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, hot foods must be maintained at an internal temperature of 135 Fahrenheit (F) or higher and cold foods must be maintained at an internal temperature of 41 F or below. The administrator failed to ensure food items were served at the proper temperature.	S3298			
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.	S3299			

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S3299	Continued From page 23 This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e) The facility had a census of 38 residents. All 38 residents ate food prepared in the same kitchen. The administrator failed to ensure food items were stored under safe and sanitary conditions by the failure to ensure foods stored in the refrigerators were kept at 41 degrees Fahrenheit (F) or lower according to Food Safety Guidelines. Findings included: - Observation of the kitchen on 07/18/22 at approximately 03:45 PM revealed a Frigidaire side-by-side refrigerator/freezer. No thermometers were found in this unit. No refrigerator/freezer temperature logs were available for review to verify staff monitored temperatures. This refrigerator contained a one-gallon plastic jug of Prairie Farms 2% milk with an expiration date of 07/10/22 and six containers of juice with no dates or labels to indicate what they were or when they were prepared. - A double-doored stainless-steel refrigerator contained a tray of dessert items was not dated, some individual dessert bowls were not covered or dated. A tall plastic container of chicken was not covered and was not dated. A plate of what appeared to be cubed cheese covered with plastic wrap was not dated or labelled. - Observation of the dry goods storage room revealed the following:	S3299		

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S3299	Continued From page 24 A large storage bag of what appeared to be penne pasta was not dated or labelled. A small storage bag of macaroni elbows not dated or labelled. Two unsealed storage bags of spaghetti not dated or labelled. A bag of corn flakes not dated or labelled. On 07/18/22 at approximately 04:10 PM, Dietary Staff E stated staff monitored refrigerator/freezer temperatures but did not log them down as there were no temperature logs provided to do so. A policy concerning food storage temperatures was requested from the facility on 07/18/22 at 03:57 PM but no policy was provided. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, "Cold foods must be maintained at an internal temperature of 41F or below." "Date mark foods appropriately, cover foods after completely cooled, cover foods to maintain cold holding temperature." The administrator failed to ensure food items were stored under safe and sanitary conditions by failing to document refrigerator/freezer temperatures.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents.	S3305		

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S3305	Continued From page 25 (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident 's food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207 (b)(4) The facility had a census of 38 residents. All 38 residents ate food prepared in the same kitchen. The administrator failed to ensure sanitary conditions for food service by not monitoring	S3305		

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S3305	Continued From page 26 dishwashing temperatures or chemical sanitization levels. Findings included: - Observation on 07/18/22 at approximately 03:56 PM revealed no dishwasher temperature/chemical sanitization log was found. - On 07/18/22 at approximately 04:10 PM, Dietary Staff E stated there was no temperature log for the dishwasher and thought the dishwasher monitored itself. According to the Kansas Department of Agriculture "Focus on Food Safety" revised August 2017, chemical sanitization required 50-200 parts per million (ppm) of chlorine or 200 ppm quaternary ammonia. For hot water temperature sanitization, the temperature must be at least 180 degrees Fahrenheit (F). The administrator failed to ensure dishwashing sanitization was monitored for and documented.	S3305		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s	S3310		

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NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
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S3310	Continued From page 27 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 38 residents. Based on interview and record review the administrator failed to ensure the facility remained in compliance with four out of five staff and one out of three residents sampled with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included: - Record review for R714 revealed an admission date of 01/06/22 with the following diagnoses: osteoarthritis and chronic pain. The 01/06/22 Admission "Functional Capacity Screen" (FCS) identified R714 required physical assistance with bathing and was independent with dressing, toileting, transfers, walking/mobility, and eating. She required supervision with management of medications and physical assistance with management of treatments. The 01/06/22 Admission "Negotiated Service Agreement" directed facility staff to provide R714 with physical assistance with bathing by turning the water on and off, washing and drying her back and feet, and washing her hair. The 01/06/22 Admission Healthcare Service Plan	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/18/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
(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 28 (HSP) directed facility staff to provide three meals a day. All other areas (nine) were left blank. R714's record lacked documentation of TB skin testing and a completed symptom questionnaire on admission. - Record review for four employees revealed the following: Certified Nurse Aide (CNA) K's employee record revealed a hire date of 10/29/21. The record lacked documentation of a two-step TB skin test or a completed symptom questionnaire within seven days of hire or after. CNA L's employee record revealed a hire date of 07/01/22. The record lacked documentation of a two-step TB skin test or a completed symptom questionnaire within seven days of hire or after. CNA M's employee record revealed a hire date of 03/03/22. The 03/25/22 (23 days after hire) first-step TB skin test was read on 03/28/22 with negative results. The record lacked documentation of the second-step TB skin test or a completed symptom questionnaire within seven days of hire. CNA N's employee record revealed a hire date of 02/25/22. The 05/25/22 (90 days after hire) symptom screen questionnaire was negative. CNA N's record lacked documentation of a two-step TB skin test within seven days of hire or after. On 07/18/22 at 11:44 AM Administrative Staff C stated she completed a symptom questionnaire on newly hired employees and thought she might have done a TB skin test on one of them.	S3310		

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/18/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE AVONLEA OF OLATHE		STREET ADDRESS, CITY, STATE, ZIP CODE 625 N LINCOLN AVENUE OLATHE, KS 66061		
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S3310	Continued From page 29 On 07/18/22 at approximately 04:45 PM Administrative Staff B stated the employees' TB test records were all she had. The administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105 regarding newly hired employees.	S3310		